

Violet Bruner Windell

Rec'd 11/16/96

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Food and Drug Administration, Dockets Managements Branch
5630 Fishers Lane, Rockville, MD 20856
Re; Docket # 82P-0316

Gentlemen or Mesdames:

I saw your address in a recent issue of Shockwaves, the publication of the Committee for Truth in Psychiatry, which I signed up with in 1995 or so when I was doing a research paper at Indiana University Southeast on my own experience with shock in 1955. When I finished the paper, I sent Linda Andre a copy but she apparently did not think I was "party line" enough, or else the people who work in this area are primarily one-cause people, and I am a person of many other causes also. At any rate, I incorporated my published magazine into a longer work, an autobiography of my life as an artist in southern Indiana. ... You may find something of interest in my search for my own truth, and indeed, I have had more trouble with the stigma, the label attached to me, and used as a power tool in the home situation which I was trying to escape from. As with any survivor, I am still interested in what both professionals and survivors are able to come out and say in any effort together to come to new truth in human behavior. I have the actual records from the mental hospital of that 1955 time, if you are interested, and they are referenced in my magazine; the only public access where they can be had is from the archival collection of my papers at Indiana University Southeast.

Enclosed is SASE for any questions or comments you might have.

Yours truly,

Violet Bruner Windell

Violet Bruner Windell

82P-0316

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PETIT
FORMAT
DANS

L'ART D'AUJOURD'HUI

du 21 décembre
au 27 décembre
2000

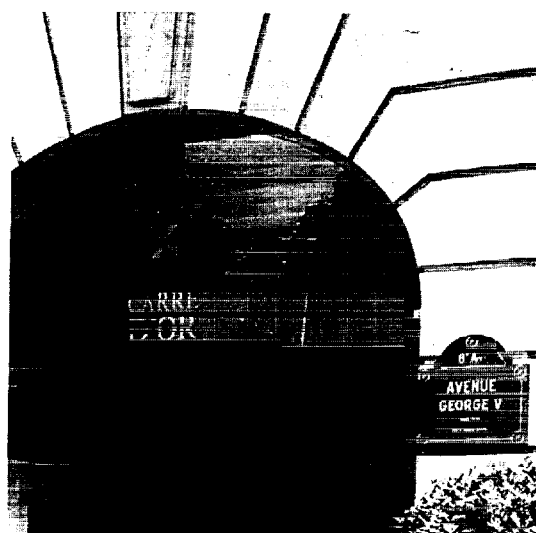
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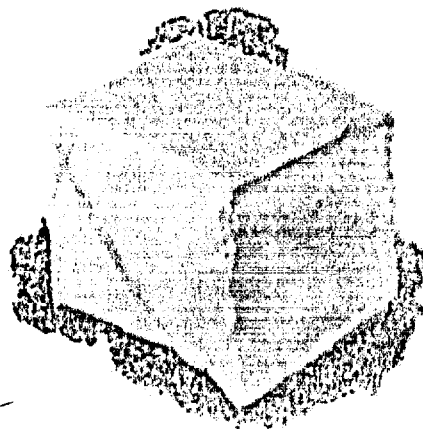
L'éditeur du Who's Who in International Art
serait heureux de vous recevoir au
cocktail-vernissage de l'exposition
à laquelle participe l'artiste

VIOLET BRUNER WINDELL

Le 21 décembre 2000 de 18h à 20h



Check out campuses. That is what Hoosier artist Violet Bruner Windell did in 1999 when she finally finished her life-span autobiography of an artist with a notebook in southern Indiana. Her Human Symbiosis is a critical study of human relationships where family members help each other when they can, but independence and self-discipline are maximized values: womansearch for power to achieve the artist's potential from a given talent is an explanation for her choice of selected library collections around the state. At seventy-seven, she is in retirement, and she said when she designed this page for COUNTRY NEWS: "I've had spaces in Art books where nobody but other artists saw them - In libraries I can reach students of all kinds, and return the life-insights I got from books in my search for truth." The book-series, completed, forms a three-dimensional piece of sculpture even if the books are not read, but only touched. Remember Rubic's Cube of the 1960's? The Bruner Windell Cube is a social model of family behaviors; it may be seen at the Skinner Farm Museum.



The 1999 Bruner Windell Colloquium

National Museum of Women in the Arts, Washington DC

Indiana University, Bloomington, IN

Indiana University Southeast, New Albany, IN

International Biographical Center, Cambridge, England

Indiana Historical Society, Smith Memorial Library, Indianapolis, IN

Indiana State Library, Indianapolis, IN

University of Louisville, Bridewell Art Library, Louisville, KY

Purdue University, Consumer and Family Sciences, Lafayette, IN

Purdue University, Purdue Collection, Life Sciences Library, Lafayette, IN

Duggan Library, Hanover College, Hanover, IN

Franklin College Library, Franklin, IN

Earlham College, Richmond, IN

Mary Anderson Center for the Arts, Mt. St. Francis, IN

Skinner Farm Museum, Perrysville, IN

WINDELL, VIOLET BRUNER

4675 Davis Mill Rd NW

Ramsey, Indiana 47166

GALLERY:

Pythias Gallery

Corydon, Indiana 47112

AWARDS:

2 place, Lincoln Hills Annual - 1966

Council of Sagamores, 1980

Medal - Outstanding people of the 20th Century,
199, International Biographical Centre,
Cambridge Eng.

EXHIBITIONS - SOLO SHOWS:

Port - O - Call Gallery, Louisville, Kentucky

State Hospital, Madison, Indiana

*Baptist Theological Seminary, Louisville, Kentucky

The only complete listing is on p. 365.

Who's Who in International Art, 1995 Lausanne, SW.
and its reproduced page in The Portfolio Index, Windell.

Today: Straight talk vs BS story in ECT statements

By Violet Windell

Windell is a long-time local artist and writer. Through the years, she has done extensive studies and written several papers on mental diverseness issues.

Dr. Max Fink's name was not one that I found in my internet survey of psychiatric authorities and their articles when I looked up a random list, statements on electroshock and behavioral disorders. However, in 1999 his book, *Electroshock: Restoring the Mind* (Oxford University Press, New York) was spotted by my brother, Dr. Paul Bruner in his ever-present browsing at academic bookstores. While from my experience in 1955 with electroshock, I might question this author's use of the word "restore" I read the book as an even-handed presentation of the present design and procedures of ECT something of its history from experimental trials to its heyday in the early fifties, when it was more and more supplanted by an arsenal of drugs. There also appears to be some kinds of behavior problems for which it was not the "cure" that any new treatment promises. So although from the fifties on, although its proud inventors continued to improve details in its design and performance, it continued to be questioned in the consumer community, as well as by government scrutiny about its safety. Many first-line hospitals wanted the expensive equipment although often its use did not justify this. The situation was and is further complicated by the the ambivalent nature of the training programs in the medical schools, where there is no consensus on the testing of medical students to qualify them to recommend or perform the treatment, if that is a client-centered last resort. Dr. Fink cites statements from results in British hospitals, where the machine is sometimes stored away in disuse and lack of maintenance. Like any other obsolete equipment, Dr. Fink says, quoting *The Lancet*, a leading professional magazine.

"Every British psychiatrist should read this report and feel ashamed and worried about the state of British psychiatry. If ECT is ever legislated against or falls into disuse it will not be because it is an ineffective or dangerous treatment. It will be because psychiatrists have failed to supervise and monitor its use adequately. It is not ECT which has brought psychiatry into disrepute. Psychiatry has done just that for ECT."

It is probably information like this that will make the anti-shock groups like Truth in Psychiatry (members Marilyn Rice, Linda Andre and others) who are working so zealously to get shock abolished through political channels—it will make their efforts redundant.

Dr. Fink devotes a whole chapter to controversy in electroshock in addition to the scattered remarks found elsewhere in his text. He mentions the caution of insurance companies in making payments for this kind of behavioral medicine. Insurance companies do not ask what part the social environment may have played in the development. Maybe they should. Privacy rights in complicity do not prove innocence and the weight of the problem is placed solely on the patient alone.

Dr. Fink has over 35 published articles by himself and/or others in his reference list, and he is well versed in that psychiatric bible from which he includes two appendices: what ECT diagnoses are indicated for in behavior problems and what they don't affect. (*American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*, Edition IV, 1994.) This publication is revised as needed, like its gradual shift from classifying homosexuality from a sickness to a life-orientation.

Dr. Fink's presentation, in short, lacks the hard sell beliefs that characterized the earlier authority statements I found by mental health spokesmen in the 1995 journals. Somewhere in the book, he says that protocol is so loose in the medical field that almost any psychiatrist with an interest in the treatment can take five days of workshop training and offer himself as credentialed to any hospital that has the machine. What he does not cover is the role of electroshock in anger management, either real anger which the patient has or the family's fear of possible anger on the part of the patient, where the "danger to self or others" come in. However, I did not find this really covered in my earlier sources either. And he could have said more about the effects on memory, depending on how much that faculty is valued by the shocked individual.

Pd. Ad.

HOCKWAVES

Journal of the Committee for Truth in Psychiatry
December 30, 1999

SPECIAL ACTION ALERT ISSUE!

The U.S. Surgeon General says that ECT is safe

Susan Rogers personally handed NIMH's Nakamura a copy of the article which disproves this claim. The CTIP editor witnessed it. In that article (A Critical Review of the Controlled Real Versus Sham ECT Studies in Depressive Illness by Dr. Graham Shepard and Dr. Saad Ahmed, 1992) every one of the thirteen sham vs. real studies ever done was evaluated. The authors conclude that "the report data at the end of the controlled phase of the studies and subsequent follow-up data does not significantly indicate that real ECT is more effective than sham ECT in treating depressive illness. Can Dr. Shepard be discredited as an anti-shock radical? Hardly. He himself gives ECT and says "can attest to its effectiveness in saving life in severe depressive illness." Moreover, his paper was presented at an important international conference organized and endorsed by Max Fink, the most vociferous shock promoter in the world.

"Well-designed neuropsychological studies have consistently shown that by several months after completion of ECT, the ability to learn and remember are normal (Calev, 1994)."

Calev is an Israeli protege of Fink's. We have not seen a 1994 study of his. However, in a 1995 study, he actually suggests that patients be warned about the risk of non-memory cognitive deficit. Dr. Nakamura was provided copies of neuropsychological studies that show that learning and memory are permanently damaged after ECT, for example: Freeman and Kendall in the *British Journal of Psychiatry*, 1980. Is he dismissing them as "poorly designed" after reading them? We doubt it---no one else has ever refuted these studies. Did he refuse to read them? Did he read the but arrogantly decide that, from his position of power, he can simply ignore any research that is critical of ECT? Dr. Nakamura was even provided with copies of neuropsychological reports of a dozen survivors, documenting brain damage from modern ECT! What they would have suggested scientist would have been: Here is convincing documentation that this area needs further investigation, and a blithe assurance that cognitive ability returns to normal is not warranted. He also provided a copy of a paper, presented at the first international conference on ECT in 1992, which summarizes much of the information on learning and memory from the FDA files.

Footnote -

II In the years of self-development scanning, I truly did not know that my one-line solution to the X (religion) Y (family life under a power struggle) problems I had was always and already to be found in the medical health records I got after I was assigned the label. Not until my latest piece of writing, *Inner Space*, was I able to see that after years of reading and research, I was ready to make the absurd statement that --no evasions, no avoidances--I thought my teacher was "That OF GOD IN EVERY PERSON," was JESUS CHRIST IN A RETURN FOR OUR TIMES. Perhaps that was an instance of being a fool for Christ, as St. Paul said, so it would have personal value for me as an experience, and it was a psychic event that I could add to the total body of work in both reading and imagery; I could use to picture a fully human Jewish prophet, a man freed of the Roman trappings of 2000 years ago, with the lingering disputes of whether he was human or 'divine'. To see this man primarily as a poet, bringing a deeper facet to spirituality such as the Greeks and Romans had brought with them, to his own culture which was ready to grow. These days there are innumerable scholars presenting this old-new Jesus, a completely "other" interpretation than the one which was a response to the needs of the Roman Empire. Which both Catholics and Protestants alike still cling to. That I do protest.

I have spent most of my adult life documenting a human model in my art ; having finished such a course, I am the reader for eternity.

82P-0316

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FORCED FORGETTING

THE ULTIMATE

IN

MEMORY / INTERFERENCE / RETRIEVAL

TRIALS

RESEARCH

Dr. Guy Wall, Development of Secondary School Programs, S510

Indiana University Southeast

*Drop Add for
Magazine-format*

Violet Bruner Windell

EAST HILL ASSOCIATES
BRANDENBURG, KY

**JOURNAL
SURVEY**

RESEARCH STUDY

INTRODUCTION

Our lifetimes rush by, filled with so many activities and entertainments that there is no time for critical thought, although some sage said that "the unexamined life is not worth living". The following paper attempts to assemble what is known to all of us by the everyday words, "blackout", and "forgetting". These simple states of mind have, nevertheless, in this century, been subject to the scrutiny of laboratory science.

Early literature on the medical procedures of shock therapy offered the hypothesis that it changed behavior because it was somehow like the near-death experience. There exist several other educated guesses to explain its results, but they remain beyond agreement. Is the near-death metaphor all that absurd? Is psychological "death", unlike somatic death, an ultimate experience in completion/interference/retrieval of something we can anticipate, instead of the venerable mystery of a death/interference/resurrection, a pious hope that still has -- but diminishing -- appeal? One can perhaps be criticized for stretching any comparison this far in a study of learning such as has scientific requirements to meet.

Still, since the development of self-esteem is an important ingredient in the teaching/learning process, there is this to be said about a result of shock therapy: it attacks the fabric on which self-esteem is based, the belief in the certainty of the self, and its worth. One reason there has not been an honest reporting of the retrieval problems of shock is that each individual considers his/her particular unfortunate experience just that, probably a rare and isolated case, "the exception that proves the rule", and makes haste to limp back into a recognizable life-pattern as soon as possible. After shock, it sometimes takes a while to regain self-esteem or belief, and if you can't believe in yourself, is anybody else going to believe in you, or even believe you, hampering future communication with others? So, any instance of social side-effects of shock-therapy are glossed over, for one just wants to function as expected, and let alone challenging the medical system.

The 80% of "cured" mania cases was the only statistic readily available, so whether this holds true or is comparable for depression, schizophrenia, and other disorders remains questionable. "Information explosion" is a household word since the seventies, but in this as in other areas, too much new information is remaining within the province of an elite, and there is not enough trickle-down to the lay people where the problems actually demand help in coping. It might be admitted, however, that part of the situation is due to the consumer public which is not all that curious about what makes us tick, for well or ill.

According to the predominant literature, then, the benefits to the patient are laudable, except for the occasional 20% mentioned where this was not the case, so according to the Food and Drug Administration, shock treatment remains in the high-risk category. Shock treatment has the strength of a cause, including a moral one. This paper should not need to be written because after fifty years of refinements in prescribing it -- something so "primitive and gross" (to paraphrase Spencer A. Rathus, a textbook author cited later) -- it should have gone the way of blood-letting, a preferred treatment for several centuries, or the cancer-cure vibrators that surfaced as soon as electricity entered the picture.

In the health field, there is much talk about "informed choice" for treatment of behavior problems -- those cognitive knots within the individual as much as his outward behaviors that disturb others. Informed choice can mean several things, for example as stated elsewhere in this paper, one gives informed consent to cut out a cancer because the death-in-pain without surgery is such a sure thing.

In the following pages I present a cursory body of information from current professional journals never seen by the consumer, about the history and development of Electroconvulsive or Electroshock Therapy as a state-of-the-art treatment for depression, not from a health standpoint so much as an adult psychological problem in learning and forgetting as well as behavioral functioning. I have cited its pernicious inclusion in modern medicine in spite of the uncertainty of how, why, or whether it is responsible for the promised results, its inflated cost to trusting consumers, and its lingering stigma, both within the individual, within family, and within the workforce. In spite of educational efforts, these consumer aftereffects remain. As for informed choice, would anybody less than terminal choose a treatment with known risks?

Appendix material includes a proposed survey to gauge how much knowledge about this modern technological procedure is getting to today's student nurses from institutions or from the community.

II

REVIEW OF THE LITERATURE

A good place to begin this study of shock-therapy is Spencer A. Rathus' note: (p 678) an Italian was watching animals being stunned at a neighboring slaughterhouse, and saw the possible use of electric shock for human application. That is about all Rathus says, but one wonders if such a discovery occurred because much of Europe was fascist in 1939, and Ugo Cerletti was a psychiatrist there. Another source modifies Rathus' claim that Cerletti was the pioneer, that American and European researchers were independently concluding that shock has potential. Harold A. Sackheim (1985) says that Electroconvulsive Therapy is used with about 60,000 to 100,000 people a year. A definitive article was written by Raymond R. Crowe (1984) in his "Current Concepts: Electroconvulsive Therapy", whose perspective includes documentations from its early years of application. On the mortality of ECT, he says that in Scandinavia from 1947 to 1952 there were 62 people who did not survive, although that might be expected during those experimental years. Crowe lists three types of adverse effects and when they may appear:

1. Those appearing during treatment
2. Those appearing on recovery from
3. Those persisting after the course of treatment is over

Crowe also mentions under PATIENT ACCEPTANCE: "Perhaps the ultimate judge of a treatment should be the person who receives it." (p 166)

Harold A. Sackheim (1993) provides information also about those early years. His article is divided into Early Reports (1942 - 1959) and Retrospective studies after 1976. Since the first use of ECT was for mania and then application shifted to depression, it is not clear why there is a gap in available documents; Sackheim just says of his short history: "There was to be no further report on the use of ECT in the treatment for mania for nearly two decades." (p 170, American Journal of Psychiatry, vol 151 n 2).

Sackheim did a simultaneous review where Sukdeb Mukherjee is credited first in 1989 and 1992. This joint article offers a statistic: "When there was a survey of 305 mental hospitals in 1942, it showed that ECT was used to treat manic patients more often than the contemporary literature on the subject indicated". (p 169, AJP n 2) Mukherjee further says, as he affirms along with Sackheim, "that improvement of cognitive functions happens because baseline impairments during the manic state are removed". (p 173, AJP n 2) He concludes:

80% of manic patients are improved, although ECT is not regarded as a first-line treatment for acute mania, but this may be in part a function of the stigma associated with this treatment (p 174, AJP n 2).

On the other hand, he says, the marked antimanic effects of ECT may not be common knowledge among psychiatrists. Mukherjee has earlier in the article used the criterion that he calls "temporal stability", (p 173, AJP n 2) a hoped-for positive result.

James W. Thompson gleans some interesting statistics from the National Institutes of Mental Health Sample Survey Programs for 1975, 1980, and 1986, this last being the year that 36,558 patients received ECT. It is not clear what the total sampled population was.

Thompson raised two significant questions, broad and critical, that largely furnished a point of departure for this paper:

Basic questions have yet to be answered, including who refers patients for ECT and why, and how ECT fits into the overall course of treatment. (p 1657, AJP n 11)

Belinda Kotin wrote an article for RN, a nursing-science periodical that I could relate to more freely than the male-dominated and pedantic psychiatrists, or the less critical level of the popular journalists whose work I found informative although less accurate sometimes. Kotin's stance as a nurse puts her nearer to the nitty-gritty of handling the person with behavioral problems than the psychiatrist who mainly diagnoses and prescribes this or that intervention. However, as may be inferred, she too reflects the values of the consumer's family and society, when she opines that successful treatment is, as she is describing shock results, (p 30)

With successive treatments, your patient's mood should improve, and he should become more capable of caring for himself and more interested in his surroundings...

I question this criterion because our being introverts or extroverts is a universal; the extrovert is interested in his surroundings including those who people it, doing things to please those people, but this is not the sum of the "normal" happy life.

Like the other writers, Kotin states her objective: "As more and more clinicians confront the limitations of psychotropic medication and psychotherapy, ECT is making a comeback". (p 26) In her recital of ECT history, she describes the primitive methods when it was given without anaesthesia, muscle-relaxants or vital-signs monitoring. In her next paragraph, however, she goes retrospective and says that "with the improvements in technique that have come about over the last twenty years, such serious complications have largely vanished." (p 26)

She cites a prevailing explanation of the beneficial effects of shock: that it raises the level of norepinephrine, a neuro-transmitter known to be deficient in many depressed patients. She cites the side effects of confusion and memory loss, which would appear to be not too high a price to pay for solution in those who have suicide plans, patients too depressed to care for themselves, and patients with no money, who would appreciate rapid treatment. She supports ECT for the senile elderly, unless they have contra-indicative heart problems or brain tumors.

Kotin, as some of the other writers, mentions the questions of bilateral or unilateral placement of the electrodes and suggests the pros and cons of either placement. The article authored by her also includes a positive pitch to prepare the patient for and encourage his/her "informed consent" to the procedure. In conclusion, she reiterates that ECT is nothing like it was in the days depicted in the mass-media play, One Flew Over the Cuckoo's Nest. "When administered by experienced clinicians and carefully monitored, ECT is far more likely to relieve suffering than to add to it". A critic might ask, "What if it only changes one kind of suffering for another, if it destroys the protective fantasy created to mask the ugliest of realities"? Attached to Kotin's article is a test by O'Toole and Waldman, available for credit through a nurses' home-study program. Some of the statements in it seem a little over-confident, for instance the statement that the amnesia (and/or confusion) will resolve itself from 24 hours to 6 months time. Perhaps it is this awareness of the amnesia after-effects that prompts Kotin, of the five researchers studied, to caution (in the page of patient instructions) to avoid making major decisions — "about your job, relationships, or finances, for instance — until you have completed the entire course of treatments". (p 29) This social factor in recovery is crucial and needs emphasis, something not even recognized by the leading articles presented.

Sackheim, Mukherjee, and Kotin, then, without qualification speak for electroshock therapy in its most positive and beneficial terms, while Thompson mainly presents a positive statement although he stresses the need for further research. True, Mukherjee mentions relevant side-effects including stigma from those the shock-survivor has known. Comments on stigma, however, are most thoroughly covered in an unpaginated leaflet provided by the U.S. Department of Health and Human Services. These are also officially recognized authorities whose works are easily found; they are also official sources citing the contra arguments in regard to shock-treatment.

OPPOSING VOICES

The opposing voice of Thomas S. Szasz has been known for some while, notably for his classic which reached the popular-book stalls, The Myth of Mental Illness. His later books and articles are in the same vein: criticism for not applying common sense to psychiatric thought. His humanistic goal for man is freedom from coercion and/or the subtleties of power abuse as a part of the persuasive mind-altering changes we can make, or even the Skinner-box behavioral medicine that is sometimes found in health facilities---notwithstanding Skinner and his box are a part of humanist contribution also, one of the paradoxes that results from the liberal imagination that characterizes humanism since the renaissance.

Perhaps it is a younger generation of Szasz's followers, whether declared or not, that apply the common-sense criteria, like the emperor's new clothes tale, to the life-problems or social aspects of the individual who seeks help. As reported in The New Scientist (Twombly, p 23)

Lee Coleman, a psychiatrist practicing at Berkeley, California says that psychiatrists, patients, and their families who allow the use of ECT are copping out...It's a quick fix. Everyone is avoiding the real cause why people are depressed, and that is because life is not going in such a good way.

It may be noted here that California's attempt to ban it altogether, mentioned by Crowe, happened in Berkeley prior to 1984. From an abstract in an encyclopedia of associations issued every year a Committee for Truth in Psychiatry is listed and described; this publication says that the FDA has consistently viewed shock-therapy as a high-risk procedure. The consumer public needs to know there is this government surveillance in case someone or another member of family goes awry to a serious extent.

If seen in a century-long perspective, it is the leading researchers in the field of cognitive processes who have, as new observations and experiments were documented, come up with a choice of explanations for problem behavior, and from all of these, medical students begin to form their philosophy and practice. This bears on Thompson's question of who refers patients to shock treatment and why; a ball-park list may at least point in the right direction; this list was drawn up for a student paper in Indiana University Southeast's counseling class:

THEORY LANDMARKS

	<u>NAMES</u>	<u>RESEARCH AREA</u>
1900	Sigmund Freud	childhood, sex
1930	Alfred Adler	power
	Carl Jung	soul, spirit
	Abraham Maslow	lifespan needs
1940	Carl Rogers	humanism
1950	Erik Erikson	7 stages of life
1960	B. F. Skinner	behaviorism

	Viktor Frankl	love, suffering, death
	Lawrence Kohlberg	self-other
	Fritz Perls	unfinished business, gestalt
1970	Kasimeirz Dabrosky	positive disintegration
1990	Carol Gilligan	feminist psychology

Does Thompson's datum, "71% of patients receiving ECT were women", (p 1657 AJP n 11), - although he does not think so -- , present a problem for further search?

Psychiatrists who prescribe shock-therapy believe in its results (or the procedure itself? Or partly because it is an admitted "quick fix"?); indeed, they would like to see those visible results offered on an outpatient basis also. From there, they could no doubt endorse it as part of any rehabilitation facility: it promises one will return to square one, if that seems a need. So simplified, what about adapting it as entertainment for the teen-age thrill-seekers along with the high-rise roller-coaster? This way they can get the "nothingness" experience without doing drugs to achieve it. What about a kit, so you can shock yourself for insights or build resistance like you build muscle? What about inclusion in grief-therapy facilities at funeral homes? Shock-therapy will get rid of a beloved face without delay as cremation gets rid of a body, and life-for-the-group goes on.

It is difficult to keep perspective in the reactions of those who object on moral grounds because of the social problems sometimes involved, for example the stigma that remains at least within one's family, more when it adversely affects one's work applications unless one lies. It is temperamental predisposition that is the birth-to-death factor which will indicate stress-tolerance, and predict job performance.

CONCLUSIONS

1. The literature shows substantially that the psychiatric community, both liberal and conservative, keeps abreast of group statistics and analyses, and ECT appears to be prescribed regularly or case-by-case, or as a last resort, and it is prescribed primarily for its "quick-fix" results with only minimal pre-treatment or follow-up attention to underlying causes. Of course, sometimes this may be due to the recalcitrance of patients, who either have so little insight they can't contribute, or don't want to because their notion of privacy seems more important. Maybe a more probing case history of the individual would be ideal, but who has time for such a caseload? Quick-fix makes for quantity, not quality.

2. The literature does not address the public education issue attached to the result in damage to self-esteem. Perhaps the writers think of this as not their area of expertise. Maybe this is not a factor in all 20% of the patients with adverse or with no appreciable effects from shock. But it is the subtle issue of basic self-esteem that other areas in human development, for instance teaching, deal with.

3. It is the esteem of others that is important to all of us. We want to be believed when we speak our opinions as we have our right to speak them freely, if in appropriate language. Indeed, I have seen the phrase "appropriate behavior" used as a criterion for mental health; still, this can't apply to the revolutionary, social or spiritual. It is the very freedom of thought that invites control by others lest it lead to actions uncomfortable for them. Self-respect and the respect of others is a paramount value: sometimes in either case, indifference is all there is.

Through shock-therapy an "unreal world", however protective it is, is destroyed. But how different is that unreal world from the world-that-could-be of the artist and the revolutionary? The same cognitive tool makes both of them.

To further scrutinize the advocacy views: we find even Sackheim complaining of a high relapse rate in shock treatment. Mukherjee alone remarks that temporal stability (the

patient's awareness of a disturbed time-concept) is an index of cure -- this invites further patient-research of a different but equally valid kind. He also mentions the stigma concern. And Thompson's statistic of the 71% of shock patients that are women might be significant, what with the rise of research in women's studies. Is shock treatment a therapy modality invented by a man, received by men practicing medicine indiscriminately on both men and women alike? A sensitive woman feels the invasive procedures of medicine, any of them, as rape. At deep-consciousness, the body doesn't know the difference as experienced trauma.

Printed in 1986 and reprinted in 1990, the U.S. Department of Health and Human Services put out a leaflet on the stigma still attached in the community to "mental illness", and their claims are verified when the case histories of Alzheimer's patients reach the files. The article says that stigma is the most debilitating handicap that "recovered" people can experience once they bear the treatment label.

The problems of stigma are everywhere. They affect all of us...In truth, the obstacles faced by recovering...patients following treatment for their illness are often as difficult to overcome as was the illness...in too many instances...even those who approach a societal definition of normal, daily face an unsympathetic, unfair, and hostile society...

...Historical physical abuse has been replaced by a less visible but no less damaging psychic cruelty...A paradox now exists. In a time of vastly increased medical sophistication, which virtually guarantees greater numbers of restored mental patients, discrimination against them continues...Research studies have found that most Americans think the two worst things that can happen to a person are leprosy and insanity. In American society, ex-convicts stand higher on the ladder of acceptance than former mental patients.

When asked to rank from least to most serious disabilities a person could be afflicted with, of a list of 21, "mental illness" ranked most. In discussing attitude changes, the article has this to say:

Even more astounding, mental patients sometimes face rejection from the professionals who are paid to treat and help them. A key finding of a 1980 forum on stigma was that many health-care professionals harbor unconscious, unstated negative feelings about their mental patients; a 1980 survey found some psychiatric nurses showed prejudice toward their patients.

This is a discouraging statistical report, for the government has the highest standards for objectivity in reporting. The prevailing community ignorance and indifference is seen in the shift of mental problems of the elderly in cases of Alzheimer's and other dementias, as they hush them away in far-off nursing facilities.

The unpredictability of ex-mental patients is the behavior critically cited by society, but this could mean that they have retained some vestige of the freedom of choice that other people have long ago given up. Something else is pinpointed in the government report and that is the myth of dangerousness, maybe a part of the same thing:

The myth of dangerousness is perpetuated through a lack of knowledge by most members of the public. The belief that mentally ill persons are to be feared has been described in the research literature as a "core belief of the American public".

It may be noted in passing that the frequency of hostility behaviors has nowhere--neither in this place nor any of the journal material earlier cited--has nothing said about it, so although it has seemed not important enough to mention, literature or studies on it must be out there, particularly in the dementias.

The article mentions that "women. . . have been found to be far more accepting of mental patients than are men." One wonders why. Incidental remarks like this throughout the literature pique one's curiosity to go further. The above summary of community perceptions about problem behavior fills out the narrow focus of the professional journals, does it better than mere student paraphrases could, and reinforces that student's choice of subject research. Shock therapy will remain unexamined as long as there is this wider context of social smokescreen surrounding problem behavior. I could have safely titled this paper, instead of something academic and acceptable, the pejorative and accusing "Shock Therapy, the Quack Treatment that will not Die."

TWO PERSONAL INTERVIEWS

In addition to the survey plan, for the study of the shock-therapy project, I previously assembled a bibliography of ten current journal references to ascertain the thought circulating about it this very year or the year before. This was called Part I of course S510. So that surely it would be live research, I present below (a) a telephone interview with Louisville psychiatrist Paul Adams and (b) Thomas S. Szasz - prolific and maverick researcher in psychology. My correspondence with THE MAN in the psychiatric field now and for several decades is significant because of his association with the State University Hospital at Syracuse, New York.

Dr. Szasz responded by return mail to my letter, as is included and can be seen, and while he did not respond per se about the shock-therapy treatment, his reprint information mentions both the stigma attached to behavioral variations and a published book of his has the subtitle: An inquiry into the social uses of mental health practices. Both of these aspects as results of ECT I have covered and will reiterate elsewhere. At any rate, these two professional psychiatrists represent the pro and con of ECT better than anything I found in the journal articles. The principle of coercion Dr. Szasz cites from my letter is between the lines elsewhere in my writing, also.

SAMPLE: INTERVIEW WITH A LOUISVILLE PSYCHIATRIST

Psychiatrists develop into such a rare breed that one seldom encounters one in everyday life, but rather has to have undergone several screening situations previously. Maybe their aloofness when one does meet with one of them bears out the frequent conviction of co-professional nurses as well as lay patients that because of his life-and-death powers over others, a doctor's ego whispers to him that he is equivalent to God -- very irritating to the others mentioned in the situation.

At any rate, my encounters with psychiatrists are three:

In 1955, when the doctor was Dr. E _____, as named in my writing elsewhere, and the place was Lady of Peace.

In 1988, in Salem, where there was a psychiatrist in residence at the Behavioral Medicine Unit of Memorial Hospital there, and Kinsey Windell was admitted as an Alzheimer's. Dr. A _____ was most cordial to me as the member of Kinsey Windell's family who also needed his help, but after a few weeks he left the area, whence I have not been able to trace him since.

In 1991, when I was attending Louisville Quaker Meeting monthly, I asked Dr. Paul Adams, who attended there also, to give me a professional "good word" for the art therapy I was doing with Kinsey Windell, and he cheerfully obliged.

So I knew he would be glad at least to hear from me again, since I had changed my meeting place to Brandenburg, closer home. Following my abstract of the Louisville phone book, I called Dr. Adams at his home for a short query of whatever he could tell me about the city psychiatric community.

Knowing I might antagonize him if he knew the whole of my project -- and I don't know how much he knows of my 1955 shock treatment, for he did not start coming to Quaker Meeting until a good while after that -- I carefully only told him that I was doing a graduate-level paper at Indiana University Southeast, a paper on shock therapy as part of a psychological study, and what could he tell me about the resources for information in the Louisville community? He seemed as cordial as I'd hoped he would be, and after a few preliminaries, the following dialogue ensued:

INTERVIEWER: Whatever you can tell me will be more than I have.

PSYCHIATRIST: Well, I don't do shock therapy, but let's see, Where can I find you some information?...It is the preferred treatment, you know...

INTERVIEWER: I found in the phone book that not only M.D.s can become specialist in psychiatry, but O.D.s also?

PSYCHIATRIST: Oh, yes, Doctor of Orthopedics, that's the other approach these days.

INTERVIEWER: Where does surgery come in here?

PSYCHIATRIST: Hmmmmm...there are all kinds of doctors that are surgeons...a neurosurgeon probably would have some kinds of psychological information related to his brain-work...

INTERVIEWER: Do you have an opinion on shock-therapy?:

PSYCHIATRIST: It's hard to say, but I'm sure that if I was in a depression, I'd want the treatment...

INTERVIEWER: (Incredulously) Really?

PSYCHIATRIST: Yes, I would...

INTERVIEWER: How could you anticipate the confusion and the amnesia?

PSYCHIATRIST: (Suavely) Oh, that often only lasts a couple of months at most, and in a year you'd never know -- or a person would never know they'd had the treatment...It's particularly useful for the elderly...

INTERVIEWER: It looks to me like the psychiatrists who advocate it are kind of fixated on the Skinner-box behavior modification technique.

PSYCHIATRIST: Not at all. Surveys have repeatedly proved that shock therapy is 80% more effective than drugs, etc...

INTERVIEWER: (thinks) Yeah, what about the 20% that are adversely affected by it? And if shock is 80% effective, are drugs alone only 40% or so effective?

PSYCHIATRIST: I'm sure I can find some material from the Kentucky Association of Psychiatrists, and I'll send it to you...it was good to hear from you, since you don't come to meeting any more.

INTERVIEWER: Brandenburg is so much closer home. But it's been so good to talk to you. And to hear your laughter.

Some are Quakers because they like to pour oil on troubled waters. But some, like me, want to stir 'em up.

END OF INTERVIEW

III

PROCEDURES

Questions that arose during the literature review were directed primarily to the descriptions and conclusions important to the suppliers of this targeted medical service, with the result that I found their conclusions very superficial except in terms of statistics and group percentages without much attention paid to basic differences in approach needed, depending on whether one's problem behavior should be regarded as a chemical imbalance, an information-processing malfunction, or a social irritant. Something else mentioned only in passing was the recognition of the economic impact that limiting behavior problems to the purely medical approach to "disease" has. More might be learned if mental health providers saw such problems as simply diversity or alternative ways of thought-processing.

DESIGN FOR PROPOSED SURVEY

The procedure here indicated is the sequence of steps involved in getting my ball-park type survey into the hands of a sufficiently informed population that the feed-back when it is returned will have

- (a) disseminated a little bit of health-learning and
 - (b) revealed areas within the test that need further reworking for clarity.
- Those steps are set forth in the proposal that goes with the kit.

Test construction is a classroom experience in the teaching/learning performance. Even in the event that this test or survey is never used with a group, it is still a design for the proposed uses. Choice of subject matter was determined by long-standing interest in psychology and behavioral science. In particular, the personal purpose for this supervised literature review and the construction of the survey has been to develop objectivity as a measuring rod of information to complement the exclusively subjective writing and publishing I have previously done which, because it is only subjective, lacks the kind of credibility I want for it.

STEPS

- A. Initial preparation of twenty questions and answers that are based on previous topics plus the community knowledge in its distance from folk interpretations of behavior and myth.
- B. Participants - a college-level age or class of 30 nursing students.
- C. Time - End of any arranged class period. Test is to take home and complete.
- D. Students will return them next class period, when I will pick them up.
- E. I will include a short discussion on the results of test and any opinions of students.
- F. Following the return of papers I will
 - (a) tabulate and analyze results. By that I mean I will count total answers attempted. If they are all attempted, the test is redundant. If too many are left unanswered, it means the material has not already been covered somewhere else. If discussion follows the testing, the test can be an educational tool to familiarize students with potential situations in the health field before they encounter them in the workplace.

- (b) correct any unclarified or unsatisfactory or inappropriate questions before using again.
- (c) offer as in-service quiz to any local facility with a nursing staff that might be interested.
- (d) give for filing in the reference section of the Corydon Public Library where I have previous work.

Of the twenty proposed questions to ask student nurses who will encounter patients with behavioral problems in the future

- (1) I have addressed hostility symptoms which are not mentioned in my reviewed authorities, yet these are significant, they do occur.
- (2) Impact on family if shock-therapy became commonplace in neighborhood clinics.
- (3) Which patients should not have shock therapy because of medical contra-indications?
- (4) How important is "informed consent" from a patient and why?
- (5) What about stigma?

These five points I felt most important to put before students, so answers would have different weights or points in evaluating. Twenty questions seemed like a good initial goal in case my supervisor decided to discard one or more in case they were irrelevant or made the exercise too long.

PROPOSAL

This opinion-survey is directed toward any student-nursing class where I can get permission at Indiana University Southeast. The hypothetical population of nursing cadets will be or have been exposed to the issues in psychiatric nursing, so they will have some kind of knowledge base, and their opinions and answers will have general value in the health field.

The survey can also have a use as a format for any discussion in any in-service seminars for nursing staff in local health facilities. Windell, the author of the test, has prepared the questions as part of the requirements for S510, where Windell's present chosen areas are community education and normal/experimental cognitive processes as presented in textbook psychology. Her goal is to make both the education and psychology fields the scientific disciplines they were originally, at least insofar as any one person can contribute anything to this broad goal.

Thanks for participating.

APPENDIX I

ECT PROCEDURES / PROTOCOLS

TWENTY QUESTIONS ON SHOCK THERAPY

FOR SURVEY OR DISCUSSION OR BOTH

1. Who decides to prescribe shock therapy and why, or for what behavior symptoms?
2. Do MD psychiatrists prescribe shock more often than OD psychiatrists?
3. Why?
4. What support-problems would arise if shock-therapy were commonly used on an outpatient basis?
5. Is the 20% of patients who do have residual complaints responsible for what little we know about patient descriptive response?
6. Why is the behavior-control issue for the convenience of others never mentioned or even indicated in the literature – for instance, in hostility behaviors?
7. Of the several theories of origins or causes of mental problems or affective disorders, why does shock treatment promise to surely treat the effect? (Particularly in the cases where it is a failure of expectations that can be identified as a cause?)
8. Is it because it is offered as a "Quick fix"?
9. How does shock-therapy affect learning processing?
10. What patient-profile absolutely forbids shock-therapy?
11. Thompson says in his statistics that persons 65 and older are given shock out of proportion to their numbers. Is this because their families, trying to take care of them, want them more docile?

12. Or are psychiatrists making hay with the older population because they are the most defenseless because the least informed?
13. Isn't the factor of informed consent rather a charade since the consent is pretty well determined when one signs in or is signed in at a facility? To be sure, a surgeon has to get your informed consent because he cuts out your cancer, and you give it because the alternative is worse.
14. Thompson wonders how ECT fits into the overall course of treatment. What besides or in tandem with ECT is tried to effect desirable thought/behavior change?
15. Is it good or bad that ECT is largely a WASP or economic aspect of the American Health picture?
16. Who needs to know the data supplied by this test, and who would find it useful in practice?
17. Is shock-therapy used following rape or child abuse convictions? If it is such a socially acceptable behavior modifier, why can't it be applied in prisons as rehabilitation? Why is it mainly directed toward those most defenseless against it, namely the elderly, the confused, and the disoriented?
18. Nurse Kotin's article is the one of the five investigators I chose who mentions the human-relations factor or risk following shock-therapy, i.e., the caution about not making major financial or social changes immediately following shock-therapy. Why is this not emphasized by at least some of the others? It should have weight as preparation for patient and family.
19. What about the stigma attached to the breakdown and therapy as is still considerable, despite public education efforts?
20. What does DSM III stand for, and what is it used for?

SHORT - ANSWERS, PLEASE
Place question number by answer
Answers may include: yes / no / maybe / probably / no opinion
~~Score will be answers attempted~~
not needed if this section
is used only as a discussion,
so pages are different than
in original Ed. Department
draft.

APPENDIX II

CORRESPONDENCE WITH THOMAS S. SZASZ

4675 Davis Mill Rd NW
Ramsey, Indiana 47166-8211

Dr. Thomas Szasz
Psychiatry, State University Hospital
750 E. Adams St.
Syracuse, NY 13210

Dear Sir:

I have corresponded with you before when I got your permission to refer to The Myth of Mental Illness in my cartoon-work of 1992 or so. I know now that your journal articles are around, and indeed, I am citing your essay in The Journal of Humanistic Psychology titled "Suicide and Psychiatric Coercion", but this is simply against the overall use of coercion in treatment, and it does not specifically mention the use of shock therapy, although from the tenor of your thought I am sure you have written an article or articles on that subject. If you do have prints of such, would you be kind enough to send me any or some? Enclosed is a dollar, because although it may not cover postage, I doubt if the usual SASE will do at all. My present school activity is graduate-level, so I hope my finished paper is adequate enough that I'll want to send you a copy. I remind you, I've been a Humanist since 1960 or thereabouts.

Thanks in advance.

Violet Bruner Windell

"I am opposed to any and all coerced (so-called) treatment and am not opposed to any voluntary participation in so-called treatment." T. Szasz

APPENDIX III

ELECTROCONVULSIVE THERAPY

The RN article (July,1993) on explanation of the procedure to a patient is a sufficient description, minus the statistics and jargon of the doctor-researcher scientific embellishments; this extract from the magazine will clarify the clinical experience for anyone who has not had it or is about to undergo it.

PATIENT INSTRUCTIONS

Electroconvulsive therapy (ECT)

The series of treatments you are about to undergo is safe and effective. It's likely to make you feel better even if medication did not. Like all treatments, however, ECT can cause side effects, and has both benefits and possible risks. Your doctor will explain them to you before your first treatment, and will describe the procedure.

When you arrive at the hospital, a nurse will ask you to lie on a bed, where she'll attach equipment that monitors your heart and blood pressure. A nurse or doctor will insert an IV in your arm, which will be used to administer anesthesia. Once you're asleep, the electrodes that will produce the shock -- and monitor your response to it -- will be attached.

Each treatment will last no more than 15 minutes, but you'll stay asleep for several minutes after the procedure. You may feel confused when you awaken, and you may not remember coming to or leaving the hospital. It can take some time for your memory to return to normal - as long as six months after you complete the entire course of treatment.

Headache is common as well in the first few hours following ECT. If it persists, take acetaminophen (Tylenol, Anacin-3, others) in order to get relief.

APPENDIX IV

Review of Normal Forgetting

In assembling relevant material on shock therapy in medicine as the ultimate memory / interference / retrieval experience, I thought it appropriate to review these three significant elements of the cognitive or learning process: below I have concentrated on forgetting as a natural consequence and how it is different from forced forgetting, sometimes an interference effected by drugs or other means.

FORGETTING - The Windell study of the invoked trauma of electroshock therapy brings up the question of forgetting as a natural process for comparison purposes. According to Spencer A. Rathus, author of the college-text series currently being used at Indiana University Southeast, present research has something to say about the biology of memory, especially the roles that neurotransmitters and RNA may play (p 255). He also mentions epinephrine (p 255) and in this connection he says that Agranoff found that fishes' learning could be interfered with by injecting puromycin—a chemical that impairs the formation of neuropeptides in the brain, preventing the consolidation of present stimuli. Rathus further says that epinephrine strengthens memory when it is released into the blood stream. The obvious question then is, how would electroshock affect the epinephrine if it lowered the amount of blood getting to the brain as some say ECT does, thus effecting forgetting? The answer is oversimplified if it is confined to the lowered amount of blood flow, as is the already known explanation for various "natural" kinds of blackouts.

These kinds of explanations on the everyday brain in its learning function are just as important to teach school children as learning the names of the bones in their bodies. Athletics teaches us body control, but as yet we have no educational approach to get this material on mental health emphasized in the curriculum, maybe as a separate subject where it could displace something less useful. Why should all the academic goodies have to wait for college-level, and so maybe never reach those who need them for a better life and better control of decision-making and choice?

MENTAL ILLNESS ~~~~~ Violet Bruner Windell



**- ALL IN THE FAMILY -
TWO ATHEISTS & A PERSON
WITH A MESSIAH COMPLEX.**

Though Hell Should Bar the Way, Windell, 1977.

COMA

Since it is thought by some researchers that the induced coma either by electric current or by insulin accounts for the excision of the troublesome thought (s), as the situation usually is, Fred Blum and Jerome Posner (1980) wrote a whole book on the researches they and others had done on coma, the unconscious state, and they came up with the Glasgow Scale, which is a rule-of-thumb measure of the behavioral differences that can be observed from light to deep coma. So it isn't, as one might first think, that there is a black / white split between conscious and unconscious. There are degrees, even of this. So much for coma as it is usually encountered in medicine. ECT is something else. Its enthusiasts sometimes seem to imply, "We don't care if we can explain it or not, if it'll fix the break." And people often act as if the comatose are dead already. This is just not true.

PROGNOSIS IN COMA

Table 24. Grades of Outcome from Coma p. 327

Good Recovery	Patients who regain the ability to conduct a normal life or, if a preexisting disability exists, to resume the previous level of activity.
Moderate disability	Patients who achieve independence in daily living but retain either physical or mental limitations that preclude resuming their previous level of function.
Severe disability	Patients who regain at least some cognitive function but depend on others for daily support.
Vegetative state	Patients who awaken but give no sign of cognitive awareness.
No recovery	Patients who remain in coma until death.

It is the controlled feature of coma in shock treatment that makes it different in an important way from the documented cases observed by Blum and Posner, and possibly a great deal can be learned about the "nothingness" of the unconscious, but only the foolhardy would volunteer for this kind of baptism by electricity.

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~~APPENDIX V~~

APPENDIX VI

Clark's article
included in full only in
Ed. Department copy, 11/5.

FIELD SURVEY

LIST OF TEN HOSPITALS COVERED
FOR THE WINDELL
SURVEY

1. University of Louisville Hospital, Deborah Payton, R.N.
2. Lady of Peace, Sharon Phillips,¹ B.S.N
3. Norton's Hospital, Nancy Fox James, ACSW
4. VA (Veterans' Affairs) Sharon West, medical Management, Psychiatry
5. Madison State Hospital (Cragmont), Jim Courter, Recreation Director
John Cutshall, Community Services Director
6. Central State Hospital (Lakeland), Dr. Jennifer Jacobs
7. Baptist East Hospital², Dr. Terese Keeling
8. Jewish Hospital/Frazier Rehab, Peri Jacobson, Assistant Vice-President, Frazier
9. Ten Broeck Hospital
10. Clark Memorial/Lifespring

¹ In the recent facilities merger this hospital has a new and more generic name, CARITAS. Most of us will long continue to call it by the old familiar regional name.

² Currently this hospital's advertising on TV has the identifying slogan: "Family Spoken Here." I wonder if it is?

The survey was done in an additional semester after the degree has been awarded, so it can or can not be admitted as part of Windell's paper on "Forced Forgetting" History and Policy on Electro-shock Therapy.

Signature _____

Date _____

October 16, 1995

Dialog with Sharon West, Medical Management Specialist in Psychiatry - Louisville, Kentucky - Veterans' Administration Hospital

Question: What is VA Hospitals Policy regarding prescription for shock-therapy today?

Answer: It is rarely given but we do give it here; I think there were five cases this year. However, it is only given after all other interventions have been tried without success. And it is only given for deep depression.

Question: Where and how is it given?

Answer: It is a small device that sits in the recovery room, so that the ECT can be conveniently administered there.

Question: What else can you tell me?

Answer: Well, there was a while that we did not give it, but as the younger doctors come in from med. school, they are less sensitive about using it, so there may be more of it as time goes on.

Questions: So it is not in question as a mode of treatment?

Answer: No, it serves a therapeutic purpose.

Question: Are your comments and answers pretty much the same as I would find throughout the VA medical/health system?

Answer: Yes, their scope of service is generally uniform. Of course, most of the VA's are facilities that do surgery, maintenance, and psychiatric disorders. However, there a few that specialize in psychiatric disorders only.

Questioner's closing remark: I am pleased to have all of this authentic information.

Staff person's closing remark: I'm glad I could be of help.

END OF INTERVIEW

4

October 21, 1995

I thought I'd drop you a line while my students were taking a test. ECT was used prior to the psychotropics in the '60's. In fact my mother had had it for post partum depression - then never was x'ed again for depression or other mental illness.

Today, ECT is more commonly used in the private inpatient hospitals for Major Depression. The x is quicker and you tend to get better results, particularly when depression is so severe, catatonic state is approaching and patient is not able to consume fluids/food, thus is at big risk for medical emergency. When used, because of the newer techniques, i.e., *an anesthesiologist hyperventilates the patient, thus when he/she seizes for that 1-2 minutes, they do not experience as much memory loss (which would result with lack of oxygen to the brain).

At Central State Hospital, because we deal with "state patients", we are mandated to get a court order for ECT (Private hospitals just have a significant family member sign a consent, unless the patient is capable of informed consent. I've only seen it used with a very psychotic, violent patient and that was after a court order was given).

I'd be glad to have lunch with you at our hospital along with a Psychiatrist who uses it at Baptist East. She'd be able to explain more indepth.

*i.e., cardiac arrest due to no fluids for days, etc.

signed, Jennifer Jacobs

November 1, 1995

Telephone interview with Nancy Fox James, Specialty Referral, Harrison County Hospital, Corydon, Indiana, from staff position, Norton's Hospital, Louisville, Kentucky.

Interviewer: This is my shock-therapy information project for a psychology paper at Indiana University Southeast. Tell me whatever I need to know...

Answer: Whatever you need to know? Well --- you know that it was first used for everything, but now it is used only for endogenous depressions...Norton's does use it. Probably most hospitals do have the facility for it...You could ask about it at Ten Broeck...no, what about Jefferson Hospital--maybe Lifespring at Clark Memorial Hospital.

It is done today with an anesthesiologist.

Question: I wanted to research shock-therapy because I had it in the 1950's and was curious about what it was like today.

Answer-by-questions, or rather reply: And how did you feel about it, positive or negative?

Questioner: Well, both ways. As a professional artist, I was particularly interested in the astonishing and complete obliteration of a particular face, or face-image, that much other experience from that time was keyed to from immediately before that breakdown-day. These hectic events I was never able to recover, including my loss of somebody's borrowed and valuable document which of course I could never return since I did not know when or where I had lost it. I either borrowed it from a Quaker in Salem or it was material written by a Quaker. She forgave me, although I was never able to forgive myself. This was a minor result of the breakdown, of course.

Answer by commentary: Your remarks are interesting. Most people who had shock-therapy in the earlier days found it horrible beyond words. It is different now, because there is less total electric current used, a shortened time-exposure, and more precise targeting of the brain-area.

Questioner's statement: I have already used 10 current professional journals for state-of-the-art interests among the professionals but my original plan for the paper was to include some actual interviews with personnel from area hospitals in the region.

I have been hesitant to ask questions for so non-professional a paper, but a collection of answers such as yours will help the dry generalities of journal reports come alive. Thanks a lot.

END OF INTERVIEW

December 18, 1995

Below is the data from Madison's State Hospital (Craigmont). The interview was arranged as a business lunch by Mary Pate, Harrison County volunteer, and the purpose was to verify my earlier phone call where a woman's voice had told me that they did not use it and had not for maybe fifteen years. Since it was a negative answer, I did not ask her why, although after I learned that Kentucky's Lakeland (State Hospital) did use it still, I was curious about the options.

Those present, besides the troupe of perhaps fifteen or so boys and men, were myself, Jim Courter, Recreation Director of the facility and John R. Cutshall, Community Services Director. The excursion is hosted yearly at Corydon.

Jim C: Violet! Good to see you after all these years!

Violet: Yeah, I'm still in there pitchin'. I'm glad I could see you today. I'll explain while we eat.

Jim C: Doing any drawing these days? Or still writing?

Violet: I'm doing some of both. My latest work has been, though, getting a second master's degree at Indiana University Southeast. Actually I'm still doing some extension of that project.

Jim C: (jokingly) Seen any more presidents?

Violet: (sternly) It wasn't a president! It was just Dr. Bowen. Governor Bowen. For that publicity shot for one of my book covers. He was probably the only "famous" model I'll ever have.

Jim C: Shux. I'd been telling everybody it was the president.

Violet: My research design for the writing exercise (can't call it a thesis because it didn't have to have a peer review or anything. Just my supervisor's ok.) calls for a survey.

Madison was the first place I called when I started that part of the project, and it's more of a quiz than anything else, just asking of maybe ten hospitals in the area if they do use shock-therapy, if so, why, if not, why not. In face-to-face interviews I can sometimes learn other things. The telephone person said you all hadn't done it for maybe fifteen years.

Jim C: That's a fact. We don't do it.

Violet: I know there have been many changes since, say, 1950, as I watched the decentralization, the farming out to group homes, etc.; so all I wanted to do was to verify with some staff person from there that it is no longer being done--I thought the phone person perhaps was just being close-mouthed, since it is still sort of controversial.

Jim C: I don't believe you could say I'm actually verifying anything. My staff duties don't extend that far. My work with the boys keeps me busy.

Violet: Nonsense! So far I've gotten replies from anybody at any facilities that would talk to me--nurses, social workers--well, I wouldn't ask a janitor for medical/social opinions.

Jim C: However, if you do get your paper shaped up, be sure to let me see a copy. (Jim picks up his empty plate and starts to rise).

Violet: Sure. I'll be glad to.

John C: Jim has one of your books. I save 'em from Louisville landfill operations when bookshops or libraries clean house and we sell 'em for a nickel apiece at our annual rummage sale.

November 20, 1995

Telephone interview with University of Louisville Hospital, Louisville, Kentucky.

VBW: I am a graduate student doing a graduate paper on the history and present policy of electroshock therapy in area hospitals, who does it and who does not, since it seems to rise and fall as a treatment. Does your place do this?

D.P.: Yes, they do it here in the in-patient facilities...This bit of information might be useful: Not all hospitals do it because malpractice insurance is so high, not all facilities can afford to offer it.

VBW: (Thinks, ah ha, that's a new point! Maybe that's what'll finally phase it out rather than the FDA or it's claim to cure when it only interrupts a problem). I had wanted to ask somebody this, because several facilities that do psychological "repair" do not offer it themselves, but rather offer referrals to other hospitals nearby which do offer it.

Thank you, thank you. This is a most useful insight. What is your name again, and what is your department?

D.P. I'm Deborah Peyton and I'm an R.N. Today I'm in Emergency Psychiatry/Therapy, but my duty rotates.

END OF INTERVIEW

November 28 - Jewish Hospital

To vary my interview procedure, I drove to Brandenburg to check out their new extension-health clinic there, told the receptionist I was surveying the present policy on shock treatment in a dozen area hospitals. She called the house director to the window, and although she had no information, she brainstormed with me for five minutes about who within the Jewish system to ask. "Frazier Rehab!" she hit on, and gave me the name, position and phone number of Peri Jacobson, associate vice-president of Frazier Rehab at their Medical Center address, although they too are developing regional clinics all over, liaoning with the hospitals.

November 29 - Full of confidence, I called Ms. Jacobson and presented my prospectus for the nth time. "I am a graduate student doing a paper on shock-therapy, and I'm doing a spot-check on maybe ten hospitals in the area who do it, have done it, or don't do it. I hope I get my ten responses. You're Jewish. I got your name and phone number from the new clinic at Brandenburg.

P.J. Answer: Well, we don't do it, so I couldn't tell you anything about it. (still a cheerful, non-judgemental voice, although by now I'm seeing the ECT prescription as controversial as abortion. I'm also chuckling as I think, "From my experience, I've spent my adult life rehabilitating from the disastrous effects of another hospital's ECT." I reply aloud).

V.B.W. Reponse: However, this is not so absurd as you might think. One of the journal sources I read was so enthusiastic about the procedure that she envisioned offering ECT on an outpatient or clinic basis. So if you're ever asked to install the equipment, remember, you heard it here first.

P.J. Answer: O.K. I'll keep that in mind. Good luck with your survey. (laughs cheerfully).

END OF INTERVIEW

December 13, 1995

This business lunch was arranged by Dr. Jennifer Jacobs with Dr. Terese Keeling, recently on staff in ECT work at Baptist East Hospital, currently with another health facility, and the most articulate medical voice encountered by this investigator during the survey.

TK: You probably know that depressions are classified in two ways--the endogenous, where the problem is chemistry caused by alterations resulting from diseases like diabetes and cancer. The other, exogenous, is caused by environmental events such as death of a relative----

VBW: I had not registered it yet, although, Jennifer, you mentioned it in your earlier note to me, and I need to know because in this "forensic" type of reconstruction I'm doing, I'm stressing the social/family issues involved during the retrieval of loss of relevant value in the person's memory and adjustment.

TK: and it is being used frequently with the elderly, where it is safer because of the altered chemistry they may already have from previously prescribed medications for other physical problems.

VBW: That is a good reason, no doubt of that.

TK: Although in the early days it was prescribed for everything --

VBW: Yes, in 1955 when I was at Lady of Peace, there were two other women from my community who were there also, although I doubt if they would open up the past merely for the sake of science. I would, though, and besides, I don't close my past.

JJ: Is shock ever used for hostility behaviors?

VBW: I didn't find this mentioned in the journal readings I did, but I was curious. Just depressions.

TK: It isn't used for that, but it -- oh, yes, remember that case in 419 last summer who had to have four-point restraints, and after a course of ECT he had recovered self-control till he evidenced no symptoms.

VBW: When I called the State Hospital in Madison, Indiana -- I've volunteered there sometimes -- I was just told that it had not been given for maybe fifteen years and at the time of my call I didn't ask why, for I was just beginning my response-survey.

JJ: There are changes coming in the healthcare system -- of course there have been drastic ones to keep up with new techniques and economics. But the state hospitals still have to have a court order, whereas family permission is enough in the private hospitals -- it's still so controversial -- Central State and Ten Broeck next door are negotiating on some kind of shared facilities on this.

VBW: Anything to help curb escalating costs.

JJ: Violet, you mentioned the memory factor in ECT. That isn't as major a factor as you might think, with the new refinements, is it?

VBW: That's what I found in the journal readings, so I don't know how valid or of value my case history from 1955 would be, and I thought I was fortunate that my supervisor let me do it at all -- other than he said he might learn something same as I did about the learning-forgetting factor in classroom teaching even among students without problems.

TK: Today there is a lot less current used, and less time involved. Too, there is more unilateral application, due to the better understanding of left and right-brain functions.

VBW: I was gratified to learn early information on that a dozen or so years ago. It kind of explained myself to me as an artist.

JJ: It seems to me that you somehow had more time to go into the nitty-gritty of your experience than a young woman with children or work usually does. Your approach kind of suggests Jungian theories.

TK: I have just covered what points I thought of. Are there more questions I can help you with?

VBW: I'm so full of new insights, after all the journal-readings of the past summer, I'm truly hearing you say all of these authentic authoritative things. Oh sure, I try to be objective in this self-analysis bit, but you ARE objective -- I'm aware of much of the chip on my shoulder, but probably not all of it. Besides, the talk with you is a double bonus --- you are an honest-to-goodness doctorate. The highest I dare go was to any of the social-work or nursing professionals, which was ok since I'm not a professional writer, either. Art's my trade.

(After goodbyes and best wishes all around, Dr. Keeling leaves the table.)

JJ: The problem of memory isn't so much in itself, I think, as the shock therapy is followed by some new effort on the part of the patient to work out --

VBW: You mean "work through" to ---

JJ: Yes --- work through to new insights in coping.

VBW: That's what I'm trying to find out. In my own case, did the shock therapy help with the right hand while hindering on the left, my facing life-problems I needed to cope with anyway. So, is shock-therapy a real help in solving life-problems or does it merely suppress them? Or is it a sleek technique that doesn't do anything except raise the insurance bill? I'm not, or want to think I'm not the garden-variety "sorehead" looking for evidence of malpractice.. but... (Ms. Jacobs and Ms. Windell discover they have a mutual friend who has published a book, so they make plans to meet again.)

END OF INTERVIEW

December 18, 1995

This note covers Ten Broeck Hospital, the private facility close by Central State. One day I called two or three hospitals, of which maybe Ten Broeck was one, indeed the best known, and it is widely known for its positive shock-therapy policy. If I did call, then I got a positive yes, but have let it go at that, because I really did not believe I would learn anything there that I hadn't already learned in the other facilities interviewed.

Like Central State, Ten Broeck is located in east Louisville, Kentucky.

December 18, 1995

I found Clark Memorial Hospital in Clarksville more difficult to contact than I had earlier assumed it would be, since the local Lifespring offices in Corydon refer their patients to the Lifespring connection that is a part of the hospital itself.

In 1989, for a year or so Salem's Memorial Hospital found some funds somewhere (probably) and started bravely out by adding a "Behavioral Medicine Unit" with its own staff psychiatrist, but this proved entirely too ambitious for such a small community, so they set their sights back after a year or so to the usual Lifespring connections with a psychiatrist from one of the metropolitan hospitals maintaining twice-a-week office hours. But the behavioral unit at its best was apparently only a stopping place for observation and medication, along with testing.

Obviously Salem's Memorial Hospital was not included in my original list of wider-community facilities, but the note is included here because of its general relevance to my incidental interest in behavioral medicine.

I did get a phone call to someone in Clark Memorial, though, and her answer was no, they did not include ECT in their psychiatric program, but on appropriate occasions used the referral agreement

November 17, 1995

Telephone interview with Sharon Phillips, Staff ECT Therapy Room, CARITAS (formerly Our Lady of Peace) Peace Center, Louisville, KY.

S.P: (Warm, friendly voice on phone) This is Sharon Phillips. What can I do for you?

VBW: I got yours and another name from the counseling division when I was there in person the other day, but it was not one of your duty-days. I am a graduate student from Indiana University Southeast, following up a suggestion from the supervisor of my research paper. My subject is the history and present policy on electro-shock as a treatment. I've done the journal reading, but my director thought, and I agreed that going out into the area and talking to some real live professionals at real live hospitals would add validity to my paper.

I chose the subject of shock-therapy because I had it in 1955 when they were still prescribing it for everything!

S.P: O.K. Yes, we still do it here, in fact, quite a bit of it. Oh, I don't mean as a standard or routine, but it is given if the person is suicidal, and/or if all other remedy has been tried.

VBW: Yes. That is what I found in the journals.

SP: The development of chemotherapy for control has much supplanted it as new drugs were found, but it is still available...It can't be used for everybody, though. None prescribed for anybody under eighteen, and/or then only with two other consulting opinions.

VBW: I came across an article in the journal material about trying out on younger than that although I didn't follow up the article to see why it was contra-indicated.

SP: One thing I've observed is that it goes in seasonal cycles--more people in after prolonged holiday times and so forth. Harder to control the memories of times past or other stresses, I suppose. More in winter than in summer. I have no proof for this other than what the admission records show, and what I've observed.

VBW: I'd read somewhere that there was a theory that longer nights and/or darkness or something to do with light might be some kind of mood factor. And hospitals say that births rise and fall with the time of the moon.

SP: Another factor is the insurance. Shock-therapy is quicker, and we like to get patients in and out of here as soon as may be, and ECT does this as compared to days, maybe weeks of slow-acting medicines. But medications are given first, and used a lot as an anti-depressant, for suicidal, for the elderly. There are several other hospitals that do ECT: Baptist, Norton's, Ten Broeck, a few that come to mind.

VBW: I don't have any more questions at this point, and your data verifies my journal readings, as well as gives further sidelights. I'd like to show you the results of my paper whenever I finish it. Would you consider this?

SP: Yes, we'd be glad to look over your paper.

VBW: I need to note what area your activities are at Peace Center, for I'd like to keep in touch.

SP: Well, I'm in ECT Therapy and I have a B.S.N.

VBW: That's a good to know, and I hadn't thought to ask. This is great.

Violet: What a surprise to hear about my books' struggle to survive!

John C: I remember you attended one of the sales, when you woodburned a portrait of one of the patients.

Jim C: (he has returned with another plate of food) One of the boys would like to talk to you and show you some of his work--

Violet: Yes, I'd like to talk art with him. Please point him out to me. I'll talk to him as I go out, which I have to do just now, for I have another appointment. Thanks again for letting me have this chance to see you and eat the wonderful food. (Exits.)

END OF INTERVIEW

CONSENSUS

There is verification between the published experts who support ECT as a valid therapy in cases of depression where other therapies have failed and the field testimonials from the interviews. I did not mention what small amount of data and authors I had gathered on the purported significant side effects arguments against the use of ECT for I wanted information uncomplicated by any hint of the subjectivity of controversy. Both the journals and the practitioners that I talked to say that the quick-fix result makes sense because of economics, that is, the high cost of health insurance. However, not in the published journal literature (that I found) is any mention of the higher possibility of malpractice in an argument of psychological or even social injury, probably because such injury would be less grossly evident than an obvious injury to bone or organ.

On the other hand, the Windell reconstruction purports to raise the question still, even from just one experience---mine--- whether ECT or EST is both dangerous and expensive, or merely unnecessary (in view of the other/supplemental agents necessary for problem-solving) and expensive. In spite of medical beliefs and presentations, among other considerations, is E C T a legitimate if minor instance of medical fraud ?

The attached pages are tentatively regarded as Appendix VI for they are a retrospective field survey of ten selected hospitals in the Kentuckiana area where I asked for a policy statement on electro-convulsive therapy as a modality in therapeutic behavior modification. An alternative use for the paper is to add it to other new material coming in after the deadline necessitated the turning in of the minimal paper, otherwise called a co-ordinating seminar.

In Forced Forgetting, I could put myself through required research paces and thus ascertain whether I had in 1955 sustained enough - if any? - actual brain damage that I would remain handicapped by cognitive deficits I had not had before. I found that my short comings in academic performance were about the same before and after, and it is interesting that my forgetting processes at age 72 are pretty much what anybody might complain of with little relation to the 1955 episode. Was I one of the lucky ones, or are complainants' exaggerating?

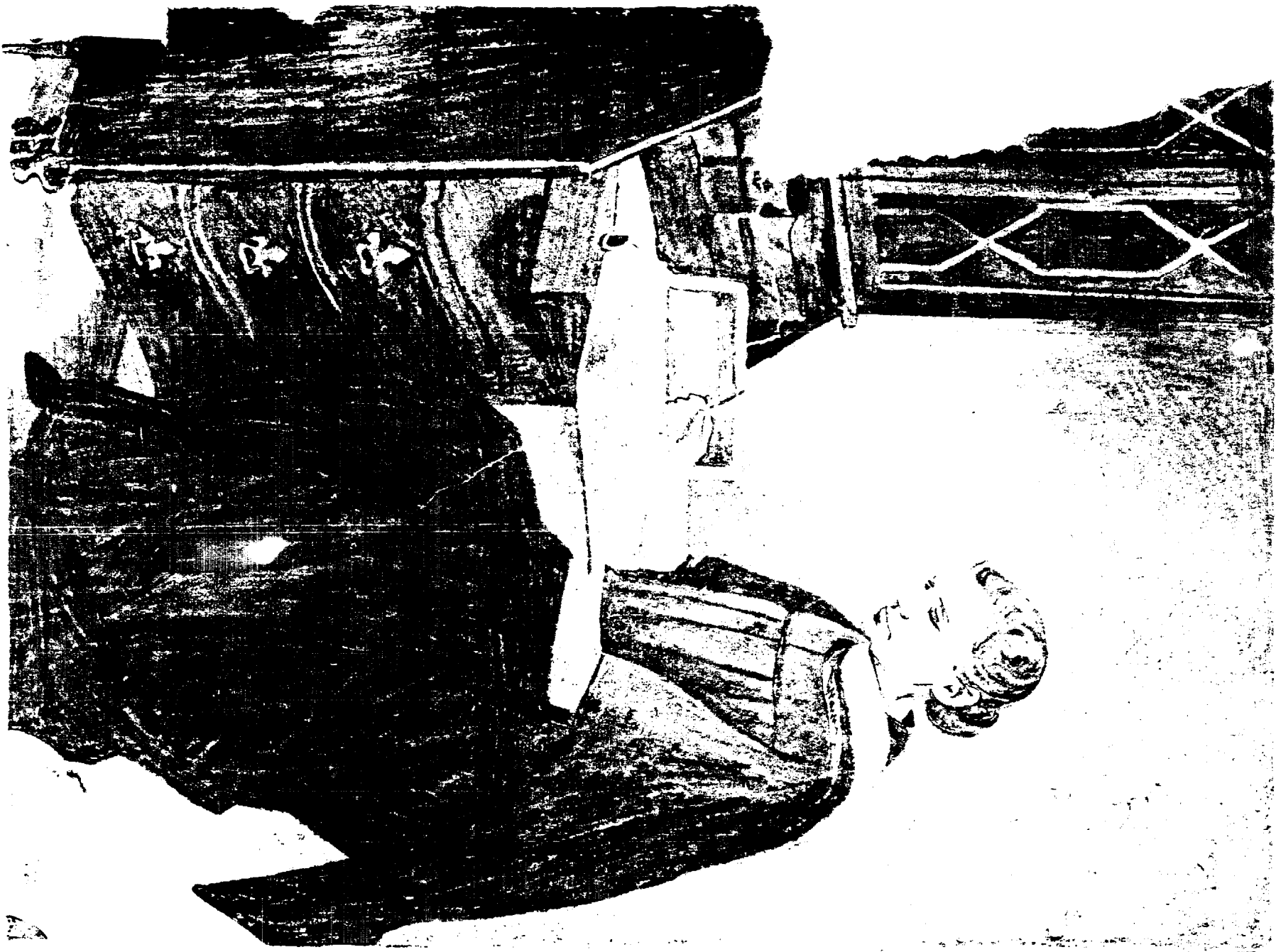
Both in the journal survey for Forced Forgetting and in these limited dialogues, I have focused primarily on and presented a study that accords with the other frequent testimonies of survivors, that the experience does affect cognitive processes to a more or less extent, although brain cells don't grow back!

RESULTS OF 10 - SITE SURVEY (COMPLETED JAN-11-96)

	VA	NORTON'S	PEACE	BAPTIST EAST	U.of LOUIS- VILLE	TEN BROCK	CENTRAL STATE	CLARK'S VILLE	MADISON STATE	1-11-96 JEWISH
DON'T DO IT								✓	✓	✓
DEPRESSION	✓	✓	✓	✓	✓	✓	✓			
VIOLENCE				✓			✓			
UNDERAGE LIMITS			✓							
INSURANCE			✓		✓					

- 7 Hospitals gave it
- 3 Hospitals did not
- 2 Hospitals were Indiana-based
- 8 Hospitals were Louisville-based
- 3 Hospitals were government-operated
- 2 Interviewees mentioned violence in behavior-problems
- 2 Interviewees cited insurance concerns
- 1 Interviewee mentioned age limits young to old

Interviewer's remarks: I was particularly gratified to find the issue of violence mentioned at all as justification, because this is more often a factor than family or even the profession wants to recognize because it is embarrassing. I know this happens in Alzheimer's behavior and also what might be described as just determination by the patient might appear as violence to scared family or friends.



Nature of Prophecy

I.

January 20, 1964

Saturday Evening Post,
January 30, 1960

56 (Continued from Page 54) millions and close; this
trillions. There is every conceivable kind ular arm
of world, in fact; and a theory of consid- office ever
erable scientific standing—Einstein be- zled her I
lieved it—is that these other possible agreeable
worlds actually exist: all of them, side by reason, al
side and simultaneously with the one we I can con
happen to be familiar with. naturally: I knew
I believed it too now, naturally: I knew
what had happened, all right. Walking
along Third Avenue the late '30s

Legend: Primal Ideas

1945 - Posing question what
valued M. Windell took
into death: a butterfly
a woman's
.....

1959 - Posing questions on
the nature of revelation

1957 - E.M. Forster's chapter
"The role of Prophecy in
Literature" Aspects of
the Novel.

SKETCH
FROM THE 60s
FILE



Windell presents paper on shock therapy at literary club meeting

Violet Windell presented a paper on shock therapy at the Feb. 8 Corydon Women's Literary Club meeting.

She completed the paper for a course at Indiana University Southeast. "Forced Forgetting" examines the re-emergence of shock therapy as a treatment for mental illness. Windell surveyed 10 hospitals. Her paper reflects the positive side of shock therapy as perceived by its proponents.

However, there are skeptics such as the grass roots organizations, "Committee for Truth in Psychiatry" and "The World Association of Shock Survivors," which seek to expose what they call "the myth of convulsive therapy."

Windell expressed the hope that IUS will be pleased that, through her course work there, she has found some groups of disgruntled shock therapy survivors who unite to tackle the medical myth that keeps society comfortable. She concluded that though shock therapy does not effectively treat the underlying mental illness of the patient, it may prevent or postpone suicide.

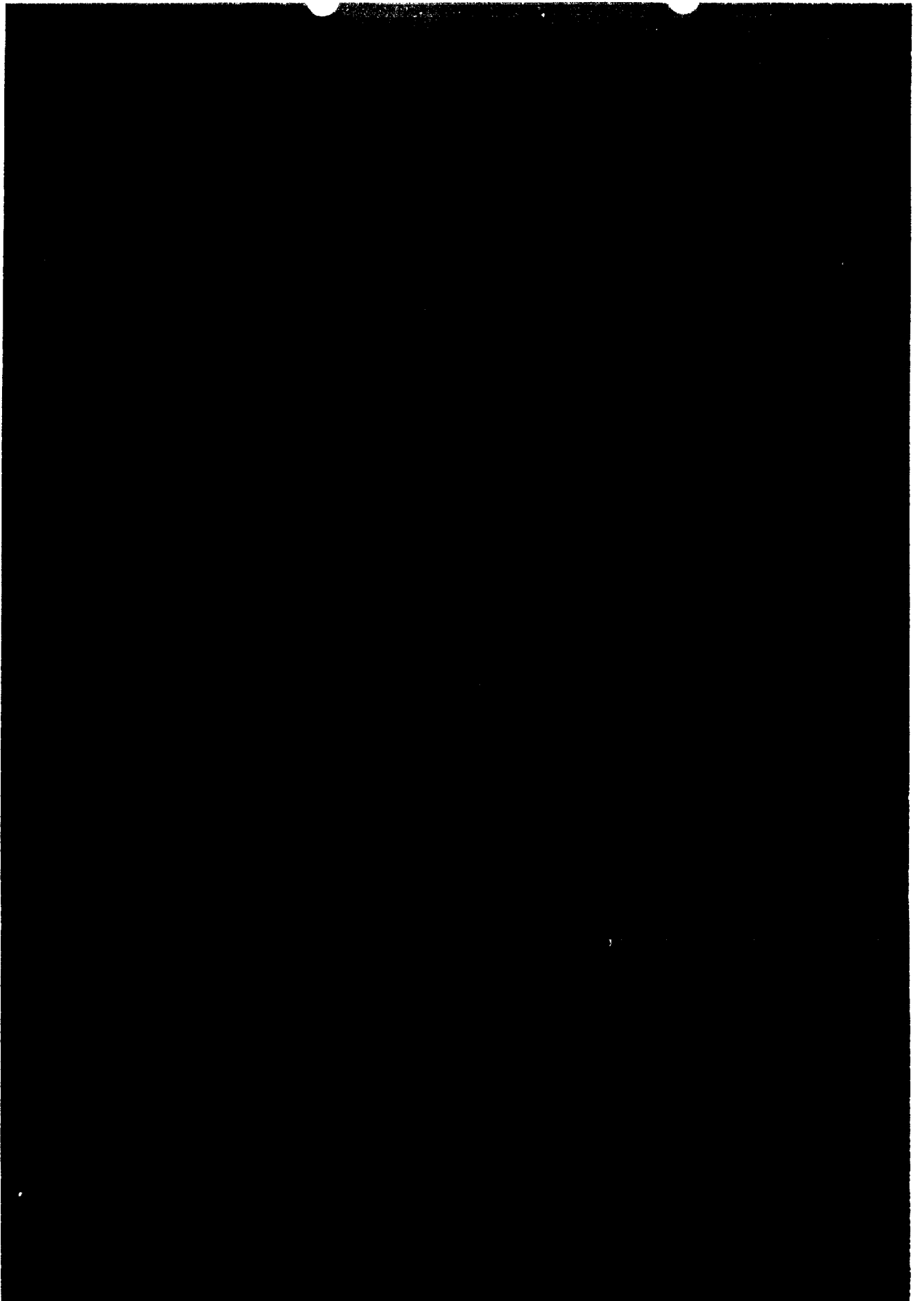
Who's Who in International Art, 1994-95, Lausanne, (Suisse)

Bruner-Windell, Violet, 4675 Davis Mill Road NW, 47166 Ramsey, (Indiana) USA. TEL: 1 (812) 738-4413. BORN: November 1, 1922, at Depauw, (Indiana), USA. NATIONALITY: American SF: widow of the late Mr. Lester Windell. CHILDREN: From this union were born Norma on January 22, 1949, Eugene on October 19 1951, Ann on June 10, 1961. EMPLOYMENT: Teaching and writing about art. MEDIUM: painting, graphics. EDUCATION: AB and AM, University of Louisville, Louisville, (Kentucky) USA, 1943, 1958, MS, Indiana University Southeast, New Albany (Indiana) USA, 1995. STUDIED with Professors Mary Nay and Justice Bier, University of Louisville 1940, 1958, Indiana University at Bloomington (Indiana) from 1967 to 1969, John Herron Art Institute, Indianapolis (Indiana) 1969 and 1970. Indiana University Southeast, New Albany (Indiana) USA, 1976 to 1995., graduate work in psychology of art in learning. SUBJECT MATTER: Conceptual art, body art/portraiture. INFLUENCES: Albrecht Durer, Georges Rouault, Walt Disney. GROUP SHOWS: State Arts Festival, French Lick (Indiana), Lincoln Hills Annual Shows, Wyandotte (Indiana) 1966 to 1976, Squire Boone Gallery, Corydon (Indiana) 1973 to 1987, judge, Floyd County Museum, New Albany (Indiana) Juried show, 1983 (?) Palm Beach Galleries (Palm Beach and New Orleans, (Florida and Louisiana, 1982 to 1984. Galerie Salamambo, Paris (France) 1988. SOLO SHOWS: Port-o-Call Gallery, Louisville (Kentucky) 1965, Squire Boone Gallery, Corydon (Indiana) 1976 to 1987, Baptist Theological Seminary, Louisville (Kentucky), 1979, Madison State Hospital, Madison (Indiana), 1980. Posey House Museum, Corydon (Indiana) 1980 and beyond, Baptist theological Seminary, Louisville (Kentucky). PURCHASE PRIZES: Indiana Triptych, bought by Conrad and Son, watercolor, Lincoln Hills Show, 1966. old State House, ceramique, Indiana National Bank, Corydon. Installation: Squire Boone ceiling, Squire Boone Main Cabin, Corydon (Indiana), 1976 and beyond. Work represented by Pythias Gallery, Corydon, 1997 and beyond. AWARDS: Council of Sagamores Governor's Award, Indianapolis (Indiana) 1980. Artists of the Gold Medal, Parma, Italy, 1981. Nomination for International Womens' Writing Guild Award "Artist of Life", 1993. National Poetry Hall of Fame, (Internet) 1977. medal: Outstanding People of the Twentieth Century, International Biographical

Centre, Cambridge, England, 1998. ASSOCIATIONS: Member of Ohio Valley yearly Meeting Society of Friends (Quakers), 1954 and beyond, American humanist Association, 1960 and beyond. National Society Daughters of the American Revolution, 1958 and beyond, National Business and Professional Women, 1971 and beyond, National Museum of Women in Art, 1989 and beyond. Kentuckiana Interfaith Council, Louisville (Kentucky), 1987 to 1992. PUBLISHED in Women Artists in America, J.L. Collins, University of Tennessee at Chattanooga (Tennessee) 1976. Artists USA - Herbert Lieberman, Philadelphia 1977-78, 1979-80, 1981-82. World Who's Who of Women (1980) International Register of Profiles 1981, Ernest Kay, International Biographical Centre, Cambridge, England. Artists of the Gold medal (Book) Nicolo Panepinto and Tendencies and Testimonies in Contemporary Art, Calogero Panepinto, Academia Italia, Parma, 1981 and 1983. Catalogue of Contemporary Artists, Georgio Svesio, Rimeco Editions, Chiasso, 1986-87. World Encyclopedia of Contemporary Artists, Franco Tralli, Bologna, Italy, Seledizione, 1984. Who's Who in American Art, Amy Furman, ed., R.R. Bowker's References, New York, 1989-90. Contemporary Graphic Artists, vol. 3, ed. Maurice Horn, Detroit, Gale Research, 1988. Her sibling, Paul W. Bruner, b. 1940, is her colleague in art, AB Indiana University, Bloomington (Indiana), study in Poland/Roumania, China, MFA Pratt institute, New York (New York) USA, doctoral candidate, Faculty, Rutgers University, New Brunswick (new Jersey) USA. her limited editions illustrated books are her autobiography, Human Symbiosis, at the American Humanist Association, Amherst (New York), Indiana University Southeast Archives, New Albany, State library, Indianapolis (all in Indiana), Art Library, university of Louisville (Kentucky), both of USA.

(Editorial note) Above is the most inclusive bio note that exists, found in the Swiss Who's Who (1995), and selected for this publication only because it has been updated by the artist, with additions exchanged for subtractions to keep to minimum original page space. This Who's Who does not accept participant artists' inclusion of the "too numerous to mention" individually placed works, a phrase which is essentially meaningless in space-apportioning for editing: Besides, I didn't do that much art! I just listed what I did - except the 1900-plus quick woodburn portraits at Squire Boone Gallery, 1973-1987, and (corporate art) sketches at Morgan Elementary School and Corydon's Justice Center, Harrison County, Indiana, USA..

VBW, March, 1998



MEMORY/ INTERFERENCE/ RETRIEVAL

P502 DEVELOPMENTAL PSYCHOLOGY (3 CR)

CONT'D...

RESEARCH STUDY

**VIOLET BRUNER WINDELL
SPRING 1996**

SHOCK THERAPY AFTER 50 YEARS

What's Healthy for Him Could Be Harmful For You

August 31, 1997

In 1995 I completed my graduate study project--in and out of college-- on the psychological and social aspects of mental breakdown, or breakthrough, helped at this time by the two lifespan courses I took at Indiana University Southeast. Sometimes it takes a lifetime to become an individual instead of a carbon copy produced in response to tradition and the assembly line.

Although mental or identity breakdown or breakthrough in its medical context is the focus of this document, which I called Forced Forgetting, its implications might be useful for the person returning from a similar incarceration, for example, the prison system. Specifically, it is the STIGMA bestowed by society, the awkwardness that arises whenever the person is at the workplace or at the family reunion, no matter how well he/she has learned to play the "expected" part again.

The thought and behavior of the person recovering from a personality or identity breakdown, means an effort, although unseen, to search for, to return to an earlier SELF, to answer the question, "Who am I? How did I get to where I am?" To find an answer that works (to use John Dewey's frequent phrase of the thirties) is necessary for functional survival. Indeed, Dewey in the decades of his writing called one of his books Art as Experience, with no qualifier of either good or bad. A theoretician, he was not satisfied with rules of perspective and accuracy being enough in art, but he rather insisted that the making of a world or a bowl is not merely a purely cerebral monologue or dialog in a search for truth. The first part of the Windell paper, Forced Forgetting, was placed in the Education Division Collection at Indiana University Southeast, which was not a difficult achievement since it was only the journal survey of what medical professionals say in favor of electroshock therapy as an intervention. The second and third parts consisted of a ten-hospital survey, and the opposing argument from Windell's reasonably accurate reconstruction of facets of her own experience in 1955 (neither methods nor results have changed all that much, but the Food and Drug Administration has never given shock therapy the ok, either). Windell named from a few case histories first of rats and then students doing things with numbers and the alphabet.

After shock-therapy, apparently there is hopefully no retrieval and life goes on as well as or better than before, but I did not find this practical or honest, because some of my motives had always been a part of my personality, and motives can't be amputated as routinely as fingers or toes. My focus was more and more away from marriage and family responsibilities, and toward a wider search for self-development.

In 1997 the completed document, both in printed format and on a computer disc, was accepted for reference in the public library in Corydon. Aside from the stigma mentioned above and reserved for any kind of deviant from majority thinking and behavior, over time I realized that self control was a lifelong problem for me (as perhaps for lots of people if the truth were known); self-control keeps us from hurting others and it is equally useful--only then it is called determination--in keeping us in spite of opposition or indifference working toward a deferred goal.

Such testimony as mine is frequently dismissed as biased and unreliable, although I knew what the criteria was for studying the case histories of others and tried to apply them to my emotions as subject-matter. Besides, I know what scientific objectivity is from having known Kinsey Windell for fifty years, however, I eventually concluded that he was not being objective by choice, but rather because he and all his family were merely predominantly left-brained, and they did not know what right-brain wiring, the genetics-generated emotion from the artist, was. True, none of this behavioral-explanation was available even to professionals, much less one's friends and neighbors, in the 1950's.

Moreover, all of my life afterward was file-keeping and questions of how my behavior appeared to other people who were too unwilling or forgetful to offer and help as witnesses for or against my research. Mostly they are all dead now, and only two credible ones remain.

A second outcome to the breakdown, as I saw it immediately following, was that you can't lie to yourself. Or at least, I couldn't; this made the breakdown a moral issue, not merely a medical one. And a third consequential question surfaced: Are men really afraid of women, if the truth were known?

The direct hit of the medical intervention shock was the destruction of my conviction that a new way of relating to spiritual reality was emerging which was truly the back-to-basics of Jesus' life, message, and death, something so portable that it could be practiced anywhere, "wherever two or three are gathered in my name", even in Harrison County. This way was not new, it was George Fox's insight that had resulted in the Society of Friends three hundred years ago. My conviction was fed by the books I was reading and by the charisma of my teacher/mentor at the University of Louisville, Ernest Hassold. He was not aware, of course; he just thought I was a perceptive student. (The charisma was manifested by his encyclopedic omniscience). As I reconstruct after decades, the fragments of my experience were more of transformation rather than "worldmaking" or a potential therefore. "Recovery" or retrieval meant that I had mistaken the scope of my conviction. It was only an insight meant for me, not for everybody, not for a few, not even my husband. It was merely a glimpse of the future, as it was becoming. A kind of worldmaking, yes. And it was in fragments - shock guaranteed that. In these late years of this century my bother Paul Bruner and I share without planning it, the joy of working at the same time on advanced degrees, I for another master's, he for a doctorate. Some while ago he sent me his classroom notes in syllabus form as he teaches design at Rutgers University, and recently I was arrested by there finding his references to John Dewey's concept of art (I had an unjust opinion of Dewey for many, earlier years). For example, Bruner (1992) writes "[Chapter IV: ART AS A WAY OF WORLDMAKING" and next places an articulation from another scholar's summary of Dewey's thought:

Emotion selects material and directs its arrangements. Without emotion, there may be craftsmanship but not art. When emotion is thoroughly absorbed in subject matter... it is manifested as the spontaneous element, yet art is the result of long periods of incubation. Dewey likens to William James description of a religious experience, and Bruner's notes on Dewey include the definition:

Art is the ideal experience as a thoroughgoing integration of subject and object in a qualitative whole. Years ago I heard an artist say, "When I paint a wave, I am the wave." A bigger surprise was my astonishment at Bruner/Dewey's statement,

The artist works with the material undergoing certain suffering and moods.

Dewey thought this, Dewey the "materialist? Where have I heard this before? From Jesus, of course; this affirmation that pain is the price paid for something of value.

Violet Bruner Windell

P502

DEVELOPMENTAL PSYCHOLOGY (3 CR)

Literature Review Grading Sheet

Dr. Diane Wille
April 9, 1996

50 points possible

50-45	A
44-40	B
39-35	C
34-30	D
29 and below	F

Content and analysis of material

5 points 10 articles/books (P502-20)

5

20 points Coverage of the material
Understanding of material
Thoroughness of coverage
(information is relevant
irrelevant info is omitted)
Integration of references

20

5 points Proper documentation
Cited material
Reference page

5

Style

5 points Proper sentence structure
Proper paragraph structure

5

Coherence and Organization

10 points Organization of paper
Logical sequence of topics
Sense of direction
Organized introduction

10

5 points Links between topics
Transitional sentences
Headings to designate major sections

5

Total points

50

Very Interesting
Paper

Indiana University Southeast
Institutional Review Board
DOCUMENTATION OF REVIEW AND APPROVAL
of
Research Project Utilizing Human Subjects

TITLE OF PROJECT _____

FUNDING SOURCE _____

PROJECT TYPE: Research _____ New _____ Continuation _____
Teaching _____ Course # _____ New _____ Repeat _____

PROJECT DURATION - START DATE _____ END DATE _____

PRIN INVESTIGATOR _____ DEPARTMENT _____

If student, name of faculty advisor _____

Campus Address _____ Telephone _____

Co-Investigator(s) _____ DEPARTMENT _____

Campus Address _____ Telephone _____

IF THIS IS A NON-COMPETING CONTINUATION APPLICATION OR EXACTLY THE SAME AS A PROTOCOL SUBMITTED AND APPROVED WITHIN THE PAST YEAR, AND THERE ARE NOT CHANGES IN SUBJECT USE PROCEDURES, THEN SIMPLY FILL OUT THIS FORM ATTACH A COPY OF ALL MATERIALS PREVIOUSLY APPROVED.

At the signature below testifies, the principal investigator(s) is pledged to conform to the following:

As one engaged in investigation utilizing human subjects, I acknowledge the rights and welfare of the human subject/patient involved

I acknowledge my responsibility as an investigator to secure the informed consent of the subject by explaining the procedures, in so far as possible, and by describing the risks as weighed against the potential benefits of the investigation.

I agree to conform to the ethical principles regarding all research involving humans as subjects as set forth in the report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research entitled, "Ethical Principles and Guidelines for the Protection of Human Subjects of Research" also known as the Belmont Report

If there is reason for me to deviate from the above, I will seek prior approval in writing from the IRB.
PRINCIPAL INVESTIGATOR(S):

(typed name) (signature)

If Student, Faculty Advisor:

This protocol for the use of human subject(s) has been reviewed and approved by the Indiana University Southeast IRB.

____ Exempt Review _____ Expedited Review _____ Full Review _____ Not Approved

Chairperson/Agent IRB Date

(typed name) (signature) (date)

This protocol for the use of human subject(s) has been reviewed and approved by the Indiana University Southeast IRB.

____ Exempt Review _____ Expedited Review _____ Full Review _____ Not Approved

Chairperson/Agent IRB Date

44

DESCRIPTIVE RESEARCH

*Education
Division
Handout*

Descriptive research studies are designed to obtain information concerning the current status of phenomena. They are directed toward determining the nature of a situation as it exists at the time of the study. There is no administration or control of a treatment as is found in experimental research. The aim is to describe "what exists" with respect to variables or conditions in a situation.

For example, a school administrator wishes to know how many first graders are likely to be enrolled in school next year in order to plan the most effective use of school facilities and staff in accommodating the total school population. There is no need to study first grade enrollment as a variable related to some other variables. In other words, the administrator is not testing a hypothesis but is seeking information to assist in decision making.

There are several types of studies that may be classified as descriptive research. These are (1) surveys, (2) developmental studies, (3) follow-up studies, (4) documentary analysis, (5) trend analyses, and (6) case studies (only appropriate for counseling majors). Although these methods may sometimes be used for hypothesis testing, they are generally classified as descriptive methods.

EXPERIMENTAL RESEARCH

It is not appropriate to focus on the structure of research studies designed for hypothesis testing. Experimental research is generally regarded as the most sophisticated research method for testing hypothesis. This method begins with a question concerning the relationship between two or more variables. At the same time, the researcher advances one or more hypothesis stating the nature of the expected relationship. The experiment is the event planned and carried out by the researcher to gather evidence relevant to the hypotheses. The experimenter deliberately and systematically introduces changes into natural phenomena and then observes the consequences of those changes. The hypotheses express expectations as to the findings that will result from the changes that are introduced. In conducting an experiment, the researcher devotes great care to the manipulation and control of variables and to the observation and measurement of results. It is through such a research method that the research can obtain the most convincing evidence of the effect that one variable has on another.

HISTORICAL RESEARCH

Historical research is the attempt to establish facts and arrive at conclusions concerning the past. The historian systematically and objectively locates, evaluates and interprets evidence from which we can learn about the past. Based on the evidence gathered, the historian makes conclusions regarding the past so as to increase our knowledge of how and why past events occurred and the process by which the past became the present. The hoped-for result is increased understanding of the present and a more rational basis for making present choices.

The historian operates under different handicaps from those of researchers in other fields. Control over treatment, measurement, and sampling is limited and there is no opportunity for replication. As in descriptive and ex post facto research, the independent or treatment variables are not controlled by the researcher. All the cautions in interpreting those studies also apply to historical research. However, in descriptive and ex post facto research, measurement can usually be controlled through deciding what measures will be administered as the dependent variable. While historians have no choice concerning what documents, relics, records, and artifacts survive the passage of time, they do have some limited control over what questions they will ask of these sources and what measures they will apply to them. When interviewing witnesses of past events and when searching the historical records, researchers can decide what questions to ask and what is to be measured. But they can measure only those things that witnesses remember or the record contains.

In descriptive and experimental research, investigators can attempt to control sampling; that is, they can decide for themselves whom they are going to study. Historians can study only those people for whom records and artifacts survive. If newspapers ignore a particular segment of a community, and no other sources for that community exist, then historians are unable to assess directly the contribution that particular segment of a population made to the life of that community.

Ary, D., Jacobs, L.C. and Razavich, A.

Introduction to Research in Education, Holt, Rinehart, and Winston, Inc. 1972.

1 Ex post facto: comparison of treatments not controlled by the researcher but naturally occurring, such as comparison of school achievement of private and public schools.

FORWARD

Violet Windell is a gentle and tender spirit who, despite some very difficult times in the past, has a deep appreciation for life. Over time, she has thought deeply about her life and its meaning. She has done so without flinching and with a genuine honesty. What follows takes its rise from hard times.

Violet sank into a deep depression and underwent a profound struggle for release. The day came when ECT seemed the only option. It was a moment of 'forced forgetting' which she has always remembered. Violet recovered from the depression and from the treatment. However, she has sought to understand the experience ever since. In the process, she has gained many insights into her life and the lives of others.

Violet applies this quest for understanding to all of her endeavors. The following is still another example of that quest. I urge the reader to enter the mind and experience of Violet Windell. You will find yourself in an extraordinary place, marked by wonder and discovery.

Allen Oliver
Brandenburg, KY
1998

Preface

Continuity and Being Present

It will be helpful to consider some facts about ordinary experience. First is the initially somewhat surprising fact that, from our point of view as subjects of experience, there are no gaps during the course of our conscious lives. Despite the fact that we are frequently and regularly unconscious (asleep, perhaps drugged, knocked out, or the like), these unconscious periods do not represent subjective pauses between periods of consciousness. That is, for the subject there is an instantaneous transition from the experience preceding the unconscious interval to the experience immediately following it. On the operating table, we hear ourselves mumble our last admonition to the anesthesiologist not to overdo the pentathol and the next instant we are aware of the florescent lights in the recovery room. Or we experience a last vague thought before falling asleep and the next experience (barring a dream, another sort of experience) is hearing the neighbor's dog at 6:00 AM. As much as we know that time has passed, nevertheless for us there has been no gap or interval between the two experiences which bracket a period of unconsciousness. I will call this fact about experience "personal subjective continuity."

Next, note that this continuity proceeds from our first experience as a child until the instant of death. For the subject, life is a single block of experience, marked by the rhythm of days, weeks, months, and years and highlighted by personal and social watersheds.

—Thomas Clark, The Humanist

December, 1995 - This year I celebrate my second master's degree, in science, in post-secondary education because there exists none in the tertiary education of lifelong learning. My verbal art became body-performance in the field in my ten contacts with ten hospitals in the area about their shock therapy policy, and the fifth appendix was an inclusion of a timely article which describes my lifework autobiography initiated following my two brief years as an instructor at Indiana University Southeast in 1958 -59, the years following my first Master's in Liberal Arts. My art-script these years is that of the researcher, organizing psychological data into a compelling proof that the memory/interference/retrieval methods used in behavioral medicine still today call for evaluation such as they will not get from practitioners. The whole of society could do with a Hippocratic question: Has my behavior hurt anybody this day?

One's creativity should not have to be justified in any community, yet if my longitudinal research study, based as it is on the birth-to-death self-development it involves, needs such justification, well, its roots lie in my early discovery that I could make a virtue of simplicity despite the middle-class poverty in which I found myself as a young adult. After my breakthrough at 33 I realized that minds were both tools and toys, something, it is supposed, that everybody has, so they are the cheapest source of both self-nourishment and entertainment, an independent source so that one need never ask any one or any place for money. My conclusion is by no means a justification for poverty nor a sure-fire recipe for survival in it. But over time I accomplished art's best goals, and took advantage of opportunities I had not expected.

INTRODUCTION

The emotional disorders that are treated with or without shock therapy might more properly be called "social illness" rather than the obsolete misnomer "mental illness"¹. This study of my own breakdown — or breakthrough — in 1955, following a year's previous identity-damage from mastectomy was a disaster because of its interfamily side-effects, which seldom get cited: In my case it solidified the power-structure in my marriage so that whatever power I developed in future would be only on my own and outside of marriage — my husband later said to somebody, "Look how she's recovered! And all by herself! Nobody helped her." Opinions like this made me think a good deal about Darwinian survival.

In the present paper I present the claims by other survivors left with their varied impairment in cognition, and no description sounds magnified, but I want to ~~offer~~ emphasize on the social aspects that I experienced, and find minimal corroboration in the remarks of others. The psychiatric profession continues to believe in ECT as a panacea, not just in the early days when I had it and it was used as a cure-all; according to present opposition literature, it is still on occasion used with youngsters and for manics as well as depressives, with the inarticulate elderly being a new additional "market". Indeed, in the 1930s, lobotomy surgery was the treatment option promising the same familiar help (House, 1960) "it may transform the depressed patient into one who is almost too easygoing. He may be overcontented with the status quo and lack the drive to pursue a planned course. He may not be able to adapt well to unexpected events. However, although there may be difficulty in abstract thinking, there is no loss of general intelligence, nor is the ability to reason on concrete matters generally impaired"². Actually, when I was a teen-ager, my grandmother read about this wonderful way to get rid of one's troubles, and she was most impressed. A way to make square pegs fit in round holes.

At present there are two main thrusts to the opposition dialogue: (A) Do more in educating the prospective shockee, so that "informed consent" to the shocker will mean something (which it does not as of now to the hospitalized person, who is in the hospital in the first place because of the inability to make clear decisions — Windell) (B) Does it really do anything for the individual's problem besides result in temporary or residual brain damage?³

Contrary to the media reporting, not just in the early experimental days, but even now, in some states and places, shock is considered harmless enough to administer to youngsters⁴ which also points up how far we have to go in understanding childhood schizophrenia (material for a further research paper! — Windell) Frank's quotation (1994) "once a schizophrenic always a schizophrenic" or depressive or whatever⁵ was so apparent to me after my breakdown that it was then I resolved to do the thoroughgoing study of all the childhood memories I could dredge up to see if there were markers, predictors, or pointers.⁶

The subject of violence does not come up in the professional literature at all, although it was at least mentioned by one of the survey participants, yet ECT is a formidable kind of violence, the invasion and destruction of one's most private store of thoughts, whether errors or truth. Most people are embarrassed by family violence, it is a major part of the human condition today, and we are not embarrassed by TV spectacles of public childbirth, nudity on the beach, and sexual intercourse. And this is ok, yet as a part of this, we are denying that anything deserves privacy, and our minds are our last bastion.

As I experienced shock treatment in 1955—and the recent oppositional literature verifies that my statements are still valid, it was a part of a contextual self-identity problem, so the shock itself was a costly and unnecessary fraud scammed onto my family and me as trusting consumers,

convinced by the priestly assumptions of the medical community, exclusive members of which do their own practices for "Privileging", some kind of licensing.

Lastly, the awareness of the self⁷ as part of the treatment-picture is mentioned neither in the literature on Forced Forgetting nor its follow-up study: maybe this is because this is what breakdown is all about.

Awareness of the self as in internally visible cognitive image or concept - that and identity itself are part of the retrieval work after shock and it can be graphically presented as a laboratory procedure involving memory/interference/retrieval in the most literal textbook sense, whether one's subjects are flatworms or people.

THE RUBE GOLDBERG MACHINE

A well-written summary of Douglas Cameron's article, "Sham Statistics", appeared in the Journal of Mind and Behavior⁸ (Winter/Spring, 1994) in which Cameron both as ECT survivor and educated opponent, fights fire with fire, as it were, in using scientific vocabulary to analyze and present the construction details that show the ECT invention for what it is, an ingenious adaptation of a cattle-prod to apply to human behavior as a health prescription for a comfortable Medicare or nest-egg savings profit. The summary which appeared in the newsletter⁹ of the Committee for Truth in Psychiatry, November 30, 1994, works well as an abstract such as any research paper begins with because the technical or academic journal is difficult for the non-professional to understand. Cameron's comparisons, although accurate, become sufficiently clear that in this summary all the physics that is needed is high school competency (1990s vintage, not 1940s!) for a general comprehension.

"Contrary to the claims of ECT experts and the ECT industry, a majority, not 'a small minority', of ECT recipients sustain permanent memory dysfunction each year as a result of ECT."

...From ECT: Sham Statistics, the Myth of Convulsive Therapy, and the Case for Consumer Misinformation, by Doug Cameron, ECT survivor and CTIP member.

The Winter/Spring 1994 issue of *The Journal of Mind and Behavior* has just come out, featuring the first article ever published to debunk the most widely believed myths about ECT: that today's "new and improved" ECT uses less electricity than in past years, and that few patients suffer permanent memory loss. It's well-researched, well-written and published in a respected journal; probably the only reason it will not be taken seriously is that it was written by a survivor. There is no other way to rebut Doug Cameron's reasonable and logical arguments.

To make his first point, that permanent memory loss all ways occurs, Cameron cites the main studies published in mainstream scientific journals, as well as the work of CTIP and its founder, the late Marilyn Rice. As he states, the reason few researchers have been interested in studying memory loss is that "Doctors (not patients) concluded that ECT was 'successful' and provided 'marked improvement'".

To make his second point, that ECT machines used today are the most powerful in history, Cameron does what no one has ever done before: used mathematical formulas to compare the outputs of all ECT machines ever sold in the U.S. The very earliest machines were renowned for brain damage and memory loss, and in the 1940s and 50s psychiatrists really tried to, and did, design machines to use the least possible amounts of elec-

tricity. But doctors complained that although these machines reduced memory and cognitive problems, they did not produce "improvement". Some doctors admitted that the brain damage effects were essential to this "improvement." By the mid-50s, the lower-electricity machines were a failed experiment; doctors refused to buy them.

However, the *idea* of the lower-electricity machines was revived by a shock doctor and shock machine company owner in the mid-70s as a public-relations scheme to help the shock industry overcome bad publicity like *One Flew Over the Cuckoo's Nest*. While advertising their machines as "brief pulse" (the type of electrical waveform used in the machines of the 1950s which can, theoretically, result in less voltage reaching the brain), the manufacturers in fact used various techniques to "soup up" the electrical charges, with the result being the most powerful---and dangerous---machines in history.

To use an analogy frequently seen in news stories about ECT: the original 1930s-40s shock machines could light up a 60-watt lightbulb for one second. Modern machines using the same type of electricity, sine-wave, can light up a 100-watt lightbulb for one second. The brief-pulse machines most commonly used today can light up a 60-watt lightbulb for up to *four seconds*!

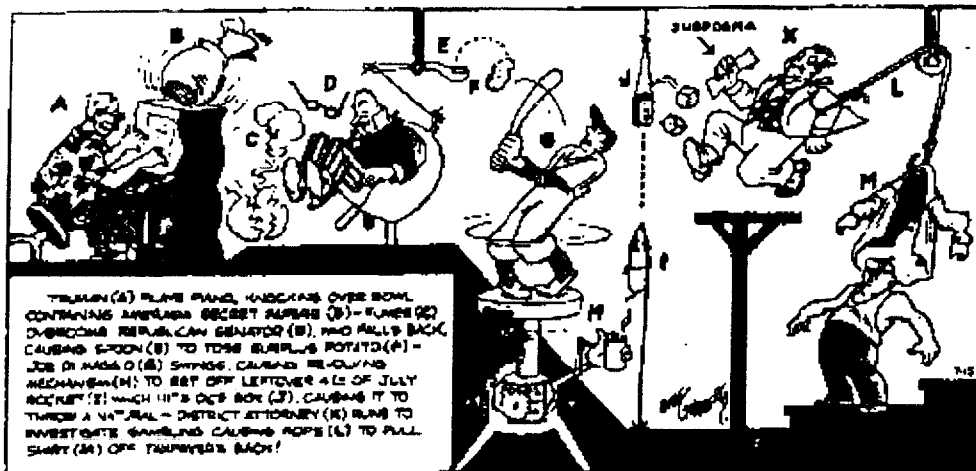
(Continued on p. 2)

CAMERON cont.

The FDA was wrong to let all ECT machines manufactured since 1976 be "grandfathered in" (that is, allowed to be sold without any proof of safety on the grounds that they are equivalent to earlier devices) since the more recent machines are so different from, and much more dangerous than, the older one. Cameron notes ironically that the ECT industry likes to dismiss the dozens of studies from the 1940s and 1950s showing brain damage from ECT as "outdated"---when in fact the machines have only gotten more powerful since then and could only cause more damage, not less.

This article needs to be in the hands of everyone who deals with the media or engages in public or personal discussions about ECT, every journalist attempting in good faith to write about it, every mental health worker or advocate or lawyer, every family member of a past or potential patient, etc! The fastest way to obtain a copy would be to order the whole journal for \$25 from the Institute for Mind and Behavior, P.O. Box 522, Village Station, NY, NY 10014. Or for the article itself at no charge, write to Doug Cameron at P.O. Box 343, San Marcos, TX 78667. Or try CTIP at P.O. Box 1214, NY NY 10003 (this will be slowest since CTIP gets so many requests for info).

For the benefit of those same 1990s high-school alumni, though, is included a visual reproduction reference to the household word for the incredible invention, familiar from the childhoods of the psychiatrist Sackheim¹⁰ (the most authoritative spokesman for ECT) and myself.



Frank, my new authority for this paper, presents at length and/or et passim the statistics he uncovered in preparing the book he wrote on shock, stating new or omitted quotes from other researchers, for example, he cites the Crowe material that I used in Forced Forgetting¹¹, where Crowe said the largest reported number of deaths from ECT was the 62 from the years 1947-1962 and Crowe's article was not published until some time later, but he does not mention an investigator named Impastato (1957) on ECT-related deaths, who had access to 214 published accounts of ECT-related deaths and 40 previously unpublished. Admittedly, it is difficult for the most conscientious researcher to keep updated on the literature, but the data casts doubt on Crowe's exclusive expertise for being "in the know". Impastato's estimate, says Frank, gives a death rate five times higher among the elderly than among the overall ECT death rates. So I don't know, considering what I've seen in nursing-home facilities during my last association with my late colleague, Kinsey Windell, whether this is society's way of sweeping the troublesome elderly under the rug (or under the sod?)

Frank's article includes this passing quote from a neurophysiologist, name of Pibram (1974): "I'd much rather have a small lobotomy than a series of electroconvulsive shocks. . . I just know what the brain looks like after a series of shocks--and it's not very pleasant to look at"¹².

Other data presented by Frank are represented here to compare and contrast with the Forced Forgetting facts and figures: About 100,00 people are shocked annually (Fink quoted in Rymer, 1989). An APA membership survey showed that 22% or 7,000 professionals used or believed in ECT. Elsewhere, the 153 hospitals responding to a survey (National Association of Private Psychiatric Hospitals) (or 83% of them for those readers who grab statistics)

58% used ECT for a variety of diagnoses
100% for depressive disorder
58% for schizophrenia
13% for obsessive-compulsive disorder

2/3 of ECT subjects are women, with a growing number of elderly as a target market. The percentage of 65 and older increased from 29% to 43% between 1977 and 1983 (Warren, 1986) Frank says that the economic factor is significant enough for a second look: "A regular User can expect yearly earnings of at least \$200,000, about twice the median income of other psychiatrists. Electroshock is a \$2 billion a year industry (italics are Frank's). Students looking for a career, take note; these guys have their own little cartel.

WHO'S WHO IN ELECTROSHOCK EXPERIENCE

And I would have liked to title this "Who's Who in ECT Survival", but some of the most important have not survived. Frank tells of

ERNEST HEMINGWAY

While undergoing a series of involuntary electroshocks at the famed Mayo Clinic in 1961, Ernest Hemingway told a visitor A. E. Hotchner, "Well, what is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient. It's a bum turn, Hotch, terrible..." (cited in Hotchner, 1967, p. 308). A few days after his release from the Mayo Clinic following a second course of ECT, Hemingway killed himself with a shotgun. With all that has been written about him since his death, no recognized figure from the world of literature, academia, law, religion or science has spoken out against those responsible for this tragedy. As might have been expected, the psychiatric profession has also been silent. Not only did the psychiatrist who electroshocked Hemingway escape the censure of his colleagues, but a few years later they elected him president of the American Psychiatric Association...

ANTONIN ARTAUD

ECT User Robert Peck titled his book *The Miracle of Shock Treatment* (1974). Antonin Artaud (cited in Sontag, 1976), the French actor and playwright, who was electroshocked in the early 1940s, wrote afterwards: "Anyone who has gone through the electric shock...never again rises out of its darkness and his life has been lowered a notch" (p. 530). In which perspective -- or at what point between these two perspectives -- is the truth to be found? This is no trivia question. For some, it will be the gravest question they will ever have to answer.

What little I knew of Artaud's thought was fascinating, because he wrote a book called The Theatre and its Double (1958) which said in its introduction that out of Artaud's travels in Mexico, he saw environmental correlations between the shapes of the native terrain and the physiognomy of the people who were born and grew up there -- the person/place correspondence that Hawthorne made much of in The Great Stone Face, where the native son looks like the face on the rock cliff. ...I wonder if I look like Harrison County, Indiana?

LEONARD ROY FRANK

Be that as it may, what Frank says about himself is this:

that last insulin coma (the only one I remember); strapped down, a tube in my nose, a hypodermic needle in my arm; sweating, starving, suffocating, struggling to move; a group of strangers around the bed grabbing at me; thinking -- where am I, what the hell is happening to me?

Well into the shock series, which took place at Twin Pines Hospital in Belmont, California, a few miles south of San Francisco, the treating psychiatrist wrote to my father:

In evaluating Leonard's progress to date, I think it is important to point out there is some slight improvement but he still has all his delusional beliefs regarding his beard, dietary regime and religious observances that he had prior to treatment. We hope that in continuing the treatments we will be

able to modify some of these beliefs so that he can make a reasonable adjustment to life. (p.77)

During the comatose phase of one of my treatments, my beard was removed – as "a therapeutic device to provoke anxiety and make some change in his body image," the consulting psychiatrist had written in his report recommending this procedure. He continued, "Consultation should be obtained from the TP [Twin Pines Hospital] attorney as to the civil rights issue – but I doubt that these are crucial. The therapeutic effort is worth it – inasmuch that he can always grow another" (p. 76). Earlier, several psychiatrists had tried unsuccessfully to persuade me to shave off my beard. "Leonard seems to attach a great deal of religious significance to the beard," the treating psychiatrist had noted at the time. He had even brought in a local rabbi to change my thinking (p. 75), but to no avail. I have no recollection of any of this: it is all from my medical records....

One day, about a week after my last treatment, I was sitting in the "day room," which was adjacent to the shock-treatment wing of the hospital building. It was just before lunch and near the end of the treatment sessions (which lasts about five hours) for those being insulin-shocked. The thick metal door separating the two areas had been left slightly ajar. Suddenly, from behind the door, I heard the scream of a young man whom I had recently come to know and who was then starting an insulin course. It was a scream like nothing I had ever heard before, an all-out scream. Hurriedly, one of the nurses closed the door. The screams, now less audible, continued a while longer. I do not remember my own screams; his, I remember.

[The insulin-coma patient] is prevented from seeing all at once the actions and treatment of those patients further along in their therapy....As much as possible, he is saved the trauma of sudden introduction to the sight of patients in different stages of coma – a sight which is not very pleasant to an unaccustomed eye. (Gralnick, 1944,p. 184)

During the years since my institutionalization, I have often asked myself how psychiatrists, or anyone else for that matter, could justify shocking a human being. Soon after I began researching my book *The History of Shock Treatment* (1978) I discovered Gordon's (1948) review of the literature in which he compiled 50 theories purporting to explain the "healing" mechanism of the various forms of shock therapy then in use.

All or at least most top tens or who's whos are probably unfair because perhaps unrepresentative. But certainly the man quoted so much so far is included below with some of the fragments of his behavior which appears so normal, or normative, or something. What kinds of charades are these?

DOUGLAS G. CAMERON: This survivor and researcher has established himself a track record, not only with the signal success of having his hard-hitting article, "Sham Statistics" in the prestigious Journal of Mind and Behavior, but it has recently been picked up from there for inclusion in a textbook for psychology. The fragments from his ECT experience I could read in Cameron's growing newsletter (WAES, 1/1/1996) among his collection of testimonials by other survivors:

"I was shocked in the 70s. I lost my college education. I lost my high school education.

This is the first time in . . . history . . . that anybody has mandated a report of deaths regardless of whether or not the doctor felt it was attributable to ECT. We had eleven people out of seventeen hundred people die. . . [S]ix of those people can be attributed to ECT. . . [E]very person . . . was in the older age category . . . When you apply it to the fifty percent who received ECT who were in the sixty-five and over category, you have a death rate of one in one hundred and thirty three older people. . . Somatics Incorporated, another manufacturer, says there's one death in fifty thousand people. They're off by a factor of two or three hundred. .

I was the first person to compare the old devices with the new devices, electrically. I put them all in the same electrical language. . . [W]hat we have with the old devices is a device with enough energy to light up a sixty watt light bulb for one second. With the new devices, we have devices which will light up that same sixty watt light bulb for four seconds." - DOUGLAS G. CAMERON, M.A. - WRITER, TEACHER - co-founder WORLD ASSOCIATION OF ELECTROSHOCK SURVIVORS - SHOCK SURVIVOR

MARILYN RICE

In 1973, at the age of 49 Marilyn Rice (cited as Natalie Parker, a pseudonym, in Roueche, 1973, underwent a series of eight ECTs at the Psychiatric Institute of Washington. Soon afterwards, ECT-caused disability forced her into early retirement from her job as an economist. She described her return to work following electroshock:

I came home from the office after that first day back feeling panicky. I didn't know where to turn. I was terrified. All my beloved knowledge, everything I had learned in my field during twenty years or more was gone. I'd lost the body of knowledge that constituted my professional skill....I'd lost my experience, my knowing. But it was worse than that. I felt I'd lost myself.(pp. 95-96)

LINDA ANDRE

Andre (1988) described her memory losses following a series of 15 ECTs at New York Hospital in New York City in 1984 when she was 24 years old:

My behavior was greatly changed; in a brain-damaged stupor, I smiled, cooperated, agreed that I had been a very sick girl and thanked the doctor for curing me. I was released from the hospital like a child just born. I knew where I lived, but I didn't recognize the person I lived with. I didn't know where I had gotten the unfamiliar clothes in the closet. I didn't know if I had any money or where it was. I didn't know the people calling me on the phone...Very, very gradually because you can't know what you don't remember - I realized that three years of my life were missing. Four years after shock, they are still missing.(p.2)...

DIANNA LOPER

"Issues such as slavery, witch burning, crucifixion, widow burning, lobotomy and clitorrectomy are not choice issues. We do not dignify them with the legitimacy of choice. Once recognized for what they are, we ban them. We disallow them. We abolish them. ECT belongs in the category of those devices which society has come to disallow because they were finally recognized as devices of inhumanity and torture - devices to control, to maim, to cause fear and terror - devices to blunt the emotions, to robotize - devices designed to make persons and groups more amenable to conformity and authority; identical to the goals of castration, lobotomy and brainwashing" - DIANNA LOPER, PROFESSIONAL LOBBYIST, co-founder WORLD ASSOCIATION OF ELECTROSHOCK SURVIVORS, SHOCK SURVIVOR

JAN WALLCRAFT: (WAES Newsletter citation, enclosure in Shockwaves, November 30, 1995), an outspoken Londoner who underwent the procedure two decades ago as a young woman, has helped to spark recent scrutiny, a help to raise media consciousness in Britain.

SYLVIA PLATH: Doctor Gordon was fitting two metal plates on either side of my head. He buckled them into place with a strap that dented my forehead, and gave me a wire to bite. I shut my eyes....Whee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant.

VIOLET BRUNER WINDELL: I'd very much like to put to some wider use the parts of my lifetime longitudinal study in the vicissitudes of self-development as an artist in the small-town Midwest; particularly Forced Forgetting, the writing requirement for my MS program at Indiana University Southeast. There is a lot of unquestioned arrogance in the journal literature and surveys that ECT is good for everybody's problems (with the cited metabolic contra-indications) across the board, forty years ago or in the nineties. I had a residue of outraged wrath from my experience, there was no recognition that I already had something of a track record as an employed artist, and I was working on a master's program at University of Louisville. Frank's article quotes a research conclusion from 1943 which validates the matter of the literature of that time: "Patients whose occupation requires intellectual ability are selected for treatment with caution"¹³. The Hemingway and Artaud experiences emphasize this point.

DISCUSSION

The opposing material has been presented; from it the reader can feel a little better informed as to what the issue is. As a kind of "control" element such as any real research paper takes account of, some results from the maturing brain-functioning memory are included. Until the last of the century we human beings would compare with regret the brightness of childhood memory, almost an automatic process, never to be repeated. Research indicates a predictable lessening of the so-called automatic kind of memory as in childhood, although in most people it is something superfluous. In my own creative body of work, it appears then that I could not have written The Fairy Bells Tinkle Afar study of childhood (1958) any later in life than I did! Not at least with any claim to factuality.

I might comment on the uniform hostility forever a potential for all of us who have had shock therapy. Were we born with more than the normal component of hostility? Or did the shock effect the insulation that keeps the hostility in control? Hostility is behind much opposition to justice. Being able to see what values were lost in shock has indeed seemed a quick process of something that might have happened over a lifetime, this balance of remembering and forgetting. So, with our present energy and determination to proclaim the truth in psychiatry, let us keep focus on what we know from experience, that the "normal" and the "artificially induced" given of forgetting are not the same thing at all.

COGNITIVE DEVELOPMENT¹⁴

We have seen that the decline in some physical characteristics during middle adulthood is not just imagined. Middle-aged adults may not see as well, run as fast, or be as healthy as in their twenties and thirties. But what about cognitive characteristics? In chapter 14, we saw that our cognitive abilities are very strong during early adulthood. Do they decline as we enter and move through middle adulthood?

The aspect of cognition that has been investigated more than any other in this regard is memory. Putting the pieces of this research together, we find that memory decline in middle adulthood is more likely to occur when long-term rather than short-term memory is involved (Craik, 1977). For example, a middle-aged man can remember a phone number he heard 10 seconds ago, but he probably won't remember it as efficiently the next day. Memory is also more likely to decline when organization and imagery are not used (Hultsch, 1971; Smith, 1977). By using memory strategies, such as organizing lists of phone numbers into different categories or imagining that the phone numbers represent different objects around the house, memory in middle adulthood can be improved. Memory also tends to decline when the information to be recalled is recently acquired information or when the information is not used often (Riege & Inman, 1981). For example, a middle-aged adult may easily remember chess moves, baseball rules, or television schedules if she has used this information extensively in the past. And finally, memory tends to decline if recall rather than recognition is required (Mandler, 1980). If the middle-aged man is shown a list of phone numbers and asked to select the numbers he heard yesterday (recognition), this can be done more efficiently than recalling the numbers without the list. Memory in middle adulthood will also decline if health is poor and attitudes are negative.

In retrospect - forgetting as a learning control -----

My study procedures from four to seventy years have been consistent--although I wouldn't call them study "habits". In childhood one screens what to remember, with related and detailed blocks of uninteresting material, and I had the support of an internal monitor, encouraging me: "I'll learn this till after the test and then I'll forget it!" Particularly numbers as singles I couldn't keep in short-term memory long enough to get answers to given problems, always a handicap in practical life. Perhaps this is why traditionally the artist escapes the practical life whenever possible. Their learning isn't the enviable straight-A of performance, excellent at everything, but rather the span from A to D, depending on many factors.

CONCLUSIONS

Spirituality Is Normal, Not Neurosis, Psychiatrists Admit¹⁵

American psychiatry has made a decisive shift by recognizing spirituality as a normal part of human life, according to a Roman Catholic priest who directs a pastoral care program.

Jesuit Fr. Walter B. Smith said the American Psychiatric Association made the shift when it approved a revision of its *Diagnostic and Statistical Manual of Mental Disorders*. For the first time it includes spiritual and religious problems as a category.

"This is a seminal breakthrough in the American practice of Psychiatry," he said. Ever since Sigmund Freud's era, the earlier tendency of psychiatry had been to treat religion as a delusion or evidence of immaturity, escapism or neurosis.

Fr. Smith holds a doctorate in clinical psychology and is president of an interreligious chaplaincy that serves 14 hospitals in New York, and provides training for chaplains.

Dr. Francis Lu, psychiatry professor at the University of California (San Francisco) and one of the authors of the new manual section on religion, said the crucial point accepted by the American Psychiatric Association was that religion is not 'pathological'.

Psychiatrists who have patients reporting problems related to religion will now read in the manual that religion is an aspect of life itself, not a disorder, and can indeed be of positive therapeutic value.

In the Kentuckiana region, specialists in the field pointed out that the Wayne Oates Institute, the interfaith/interreligious Cathedral Heritage Foundation's community forum, and diverse other professional and lay groups locally "have for many years proceeded and succeeded with that understanding." "This approach has long been at the heart also of (Dr. Robert) Coles' work with patients and their families, as his published works as a world-renowned child psychologist show," a local therapist observed.

Instruction in the area of religion and spirituality has now become a requirement for doctors who are in a residency program for psychiatry.

-The Horizon, Kentuckiana Interfaith Community
December, 1995

Even as I write, I see that the procedures of the APA have finally seen the light that spirituality is not an illness to be treated after all. So much for all of the creative diversions to cope with or sublimate my original social relationships problem, culminating in the strenuous work of including it some way in all of my other projects I've done over the years. This APA, moving ahead from 1955 to 1996, has been the source of vindication, not me. And it is enough.

March 24, 1996. I regret that Clifford W. Beers¹⁶ and his A Mind that Found Itself (1955) did not surface to my attention while I was compiling my 20th Century list of Important Contributors to Theory and Practice in Psychiatry (Forced Forgetting, 1995) because I always referred to him as one of the thinkers who helped the most in my retrieval task of the nineteen fifties. Therefore it was a refreshing read while preparing this paper to go again through his account of his breakdown and institutionalization at the turn of this century, watching him work through to objectivity/reality

without the present-day major drugs or brain surgery or electroconvulsive therapy or even counseling of any significance instead of just custody. In his book, Beers has a statement from his contemporary, Professor William James, who points with insight to the "crisis point" in Beers' return to reality, as it begins with his delusions about family (corroborating my insistence that we are talking about family environment which makes behavioral problems a "social illness", if it must be called an illness at all, which Szasz says is a misnomer!) The letter from Professor James (1906) that cites this crisis point says

The most striking thing...to my mind is the sudden conversion of you from a delusional subject to a maniacal one--how the whole delusional system disintegrated the moment one pin was drawn out by proving your brother to be genuine. I never heard of so rapid a change in a mental system, (Beers, p. 143)

And Professor James is in command of the whole case study for Beers has described earlier and graphically the family situation that obtained, in the beginning of his annihilation of trust in family:

"If the man I had accepted as my brother was spurious, so was everybody. That was my deduction. For more than two years I was without relatives or friends, in fact, without a world, except that one created by my own mind from the chaos that reigned in it" (Beers p.28).

This is explained by his self-imposed silence during this time, a behavioral response alike frustrating to family and medical staff. Indeed, there is a "crisis point" in mental breakdown as they said at the dark ages of that time, although sound medical wisdom, primarily of pneumonia fever, but perhaps of typhoid fever also; It was the abrupt temperature drop, when family knew that the patient would recover. Obviously, temperature as a physical symptom in "disease", insight as a cognitive one, if breakdown is an "illness".

In my breakdown, my crisis was after I came home, still fruitlessly grasping for lost thoughts, still determined in renewal, "I will be a better wife to Lester", and the psychiatrist advised, "Let her continue to go to school". LET HER CONTINUE..? But while I was groping for the lost thoughts, I just looked at Kinsey Windell and I realized, "I'm not interested in religion. I'm interested in YOU". Not that I could say this aloud.

So my underlying problem in retrieval was not to rejoin the Windell family with their logical/rational and objective expectations, but to reaffirm the subjective values that led to the Bruner family emotions I had deliberately left behind by my choice of marriage and for genetics' sake. Contrary to the dominant hope of family and society (objectivity in all things being somehow superior to the vagaries of subjectivity in the humanities because objectivity was the poor man's "golden mean" of Aristotle, and this was the value of people who got things done).

Questions of determination in what goals to have in life are not raised in a paper of this nature, yet maybe they should be because it was an intended or purported result of ECT to at least sidetrack some of those "undesirable" goals. Which it did, no fault of medicine because it did not destroy, but I think goals and genes are unreachable because they are connected. I take a liberty in saying here what an old neighborhood farmwife's remark was of me, a superstition common enough then, "Poor girl. She studied too hard".

Shock therapy, then, had not made me graft on an objectivity so expected by society and family but it was the cherishing word I read in a short note from professor Ernest Hassold later in summer correspondence when I told him I was repainting our house for therapy, and he replied about that and about my return to school in the fall: "I'm glad you're so objective about your experience". Alas, in over forty-five years, I have lost that precious document.

The development of an inner world is the unquestioned play activity of every child so neurally endowed by heredity as an escape from sameness and boredom. Adult life-patterns all too soon crowd out this activity, except the performing-arts folk who sometimes succeed in holding on to

and adapting it. Sometimes indeed it achieves considerable sophistication, which appears to justify such a life-style.

Of the 1955 breakdown, I have regretted most the major handicap, the total eradication of a height of over-confidence, dimly remembered and never to be matched again, although the task-achievements of reality have formed a respectable body of professional work. It was a sense of power, if you will. I had never attempted so much to bring a social dream into reality, and if I did not know before, I knew afterward that I might fail. My ideas for social improvement were so good, how could I fail of acceptance for them?

That excess of overconfidence, even if balanced by the pain involved -- like childbirth -- as described by Clifford Beers has a familiar ring, and for that feeling again of overconfidence during 1955, I would give anything, anything. Naivete?

And if, then, I have a conclusion about ECT, it is that in breakdown whatever retrieval problems present themselves to the survivor will have to be solved as if the interference of the electrotherapy had never happened. This is not easy feat of mind. On this hypothesis, why should it happen?

NOTES

1. Thomas S. Szasz lodged a highly vocal protest in the nineteen sixties with his book The Myth of Mental Illness.

2. Earl Lawrence House, 1960, Functional Approach to Neuroanatomy.

3. Yes, according to leaflet materials from Head Injury Hotline.

4. The 1947 study by Dr. Laurretta Bender appears to be a kind of pilot study for variant-age applications of shock, although it may not have been replicated. In general, the shock practice was dropped for children as drugs became more refined, notwithstanding it is still part of the states' package for regulating, according to Shock Waves, a 1995 newsletter from West Virginia, reporting on a legislative issue introduced to outlaw the use of ECT on anyone between 13 and 17 and only then with the consent of two psychiatrists. ECT for children under 12 would have been labelled "experimental". The bill did not pass. There are perhaps other efforts being made, buried in some back pages of newspapers here and there.

As with another reference included in the appendices, for the person interested in breakdown, break with reality, with or without shock therapy, the creation of an "inner world" is interesting at any age, although this is not part of the thrust against the practice of childhood ECT. A fictional process is included as an arresting non-clinical glimpse. It is a segment from Hannah Green's I Never Promised You a Rose Garden; in Green's popular book (1964) that author presents the Deborah Blau case study where the teen-age girl is placed in an institution and we see from the inside the Oz Land, this one an everpresent inner world in a land named Yarri, peopled with authority-characters like Anterrabae who made her do things from commands in a nonsense language. Through conversation with an old mad teacher also in the institution, Debbie gets self-understanding when she remembers the reality roots, the visual illustrations in her grandfather's copy of Milton's Paradise Lost. So much for childhood mind and the tiny seed from which the luxurious and exotic plant will grow.

5. Leonard Roy Frank's article quotes numerous critical opinions and testimonials in Taking Sides (Ed. Brent Slife).

6. Violet Bruner Windell, 1958; Thoroughly covered longitudinal study of her own childhood in section 1 of a larger document Human Symbiosis. The childhood section is called The Fairy Bells Tinkle Afar. *Written at that time but not published until 1968.*

7. This reference to the self -- or identity problems -- was mentioned earlier, my source being the Head Injury people. See references.

8. As it came from the Journal of Mind and Behavior. Cameron's article was authoritative but difficult to follow by a lay reader.

9. However, its abstract as used in the Shock Waves newsletter is quite clear; this article also announces that it will be used in a forthcoming psychology book.

10. The Rube Goldberg cartoon is from Compton's Encyclopedia 1993 although the art was first published in the nineteen twenties, that is his work was appearing then.

11. Details of the Crowe materials extensively treated in Windell, 1995, Forced Forgetting, unpublished manuscript, Education file, Indiana University Southeast.

12. Another person and quote cited from Frank's article.

13. Frank cites researcher Herskovitz for this critical conclusion.

14. John W. Santrock, Lifespan Development, the psychology textbook used in P502, 1996.

15. The Horizon, 1996, publication bimonthly, Kentuckiana Interfaith Community, Louisville, Kentucky.

16. Remarks on a re-reading of Clifford Beers' work, closing text-body of retrieval and in an appendix also.

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**Asterisks indicate references used both in text-body and in appendix, because the latter is designed for mobility, to use with or without text-body.*

APPENDICES* DOCUMENTS ETC.

APPENDIX A - The Yeats' Poetry, circa 1940's - apocalyptic thinking among the literati

APPENDIX B - Random Class notes: Indiana University Southeast, circa 1990 - 1994

APPENDIX C - Bowra's treatment of Alberti's breakdown

APPENDIX D - Book review, Beers' Mind That Found Itself, read 1957. Reread, 1996

APPENDIX E - The Hundred Children shock material

APPENDIX F - Letters

APPENDIX G - LIVING WITNESSES, BROTHER & SON

*Two areas of process-approach had to be learned in the preparation of this paper:

A. Recognition of the important differences between APA style of construction for bibliographical data and older methods required for humanities standards being offered in the nineteen sixties: however, the latest APA style manual says that although singular-plural in math vocabulary such as "matrix/matrices" is correct, what is preferred for appendix is appendixes, not appendices as I have used it above. Is this one of the inconsistencies of the English language, or is the very word appendix in common vocabulary the exclusively personal and anatomical work never used except in a medical diagnosis, therefore always singular? If I use the alternate spelling, it is because I'd rather be consistent than right.

B. Attached to this paper are samples of the scanning process as applied to the otherwise straight word-processing used in the format of the modern computer.

April 13, 1996

Nor do I understand how I came to omit the shock-related study called "The Effects of Punishment On Learning" made "famous" by Stanley Milgram in 1963 at Yale University, although his innocuous title covered his real research which was to discover how far students would go in obeying a morally "wrong" procedure -- Milgram here was playing a deadly game, for his shocks weren't to real people, but in other cities, other situations, real shocks had been administered for twenty years, with no outraged protest.

So although the immorality of electroshock does not surface with the survivors testimonies presented, maybe if shock is considered immoral in the laboratory it should be considered so also in psychiatric therapy. If there was such publicity about the morality fake shock, why no publicity about the morality of real shock, and is it justifiable?

APPENDIX A

The Tower

Sailing to Byzantium

I

That is no country for old men. The young
In one another's arms, birds in the trees,
-Those dying generations -- at their song,
The salmon-falls, the mackerel-crowded seas,
Fish, flesh, or fowl, commend all summer long
Whatever is begotten, born, and dies.
Caught in that sensual music all neglect
Monuments of unaging intellect.

II

An aged man is but a paltry thing,
A tattered coat upon a stick, unless
Soul clap its hands and sing, and louder sing
For every tatter in its mortal dress,
Nor is there singing school but studying
Monuments of its own magnificence;
And therefore I have sailed the seas and come
To the holy city of Byzantium.

III

O sages standing in God's holy fire
As in the gold mosaic of a wall,
Come from the holy fire, perne in a gyre,
And be the singing-masters of my soul.
Consume my heart away; sick with desire
And fastened to a dying animal
It knows not what it is; and gather me
Into the artifice of eternity.

IV

Once out of nature I shall never take
My bodily form from any natural thing,
But such a form as Grecian goldsmiths make
Of hammered gold and gold enamelling
To keep a drowsy Emperor awake;
Or set upon a golden bough to sing
To lords and ladies of Byzantium
Of what is past, or passing, or to come.

The Second Coming

Turning and turning in the widening gyre
The falcon cannot hear the falconer;
Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed, and everywhere
The ceremony of innocence is drowned;
The best lack all conviction, while the worst
Are full of passionate intensity.

Surely some revelation is at hand;
Surely the Second Coming is at hand.
The Second Coming! Hardly are those words out
When a vast image out of *Spiritus Mundi*
Troubles my sight: somewhere in sands of the desert
A shape with lion body and the head of a man,
A gaze blank and pitiless as the sun,
Is moving its slow thighs, while all about it
Reel shadows of the indignant desert birds.
The darkness drops again; but now I know
That twenty centuries of stony sleep
Were vexed to nightmare by a rocking cradle,
And what rough beast, its hour come round at last,
Slouches towards Bethlehem to be born?

APPENDIX B

The opposing materials that I have presented rightly focus on the cognitive results of the breakdown/shocktherapy, but they only indicate boundaries involving other people. I have included additional aspects of my case history that I felt necessary for an objective presentation. Of my two-layered social problem the first part to consider might be the long term division of marital power that I orally described in a counseling class G 502, at Indiana University Southeast in 1994:

I married into an orderly family that did not live by emotions, they lived by logic, although this left out some of my incipient values. In midlife (at thirty plus) I lost a breast to cancer, and faced death. I took up a religious opportunity that presented itself - - Louisville Quaker Meeting, because I was seeking God - - not just for myself, but for the children I now had. The Society of Friends seemed to allow more free thought because it was not so . . . well . . . "churchy."

I got into a mental institution and had the band-aid fix of electroshock therapy, so when I came home, I saw two realities:

(A) I was in love with - - or rather dependent on - - a man I was not married to and (B) I was an artist or I was NOTHING. (I was graduated with an A B in art history the same year - - even the same week I married. Too many events at one time).

After the Lady of Peace trip, of course I couldn't say what I now saw about "the other man," or my family - - and the other man too would have said I was still crazy. I wanted to get on with my life, so I applied myself to graduate study and finished my MA, this time in English and Humanities, so I would be eligible for teaching. Meanwhile, my frustration in trying to get access to my medical records went on for five years and it was a major point Lester Windell and I fought over--- it was a n empty space that I had to fill. Finally, with my obstetrician's help, I was able to do this. And again, I wanted nothing to do with the law, medical law this time, when I saw by what a cover-up it could smother strife, intrusiveness and hurt.

The spiritual dilemma which was the second part of my breakdown thinking, I covered orally also in a Women in Religion class R300 at IUS in 1992:

In the rural small town Bible Belt culture where I lived, and with my father a minister, it was traditional and logical to try God first when things weren't going well at home . . . although a Quaker notion of God was about as exotic and quixotic as none at all. I was intrigued by the notion of a female variant of messiahship. This is documented in the records for 1955 at Lady of Peace Hospital. So if I accomplished nothing else with my life, perhaps I could be among the other firsts and lasts of the century, the last person to develop a messiah complex. I hoped so for our world is more than ready to have new kinds of leadership. Or, if not me as a leader, then my beautiful and omniscient teacher—of the mystical name Christopher—and the white hair—E.C. Hassold—if he would become a member of our Quaker Meeting, everything else would follow. But how would a man know if he was the Messiah, unless somebody asked him? In his classroom, probably whatever I asked was some form of that question. Somewhere through the ECT blur, I heard him saying with firmness, "Mrs. Windell, I am teaching a class." He may have repeated this. Then he and the class left the room.

So he was not the Messiah. I had made a disastrous mistake. I had been betrayed by academia, the rock in my life. I was confused and abashed, with an embarrassment far worse than any unremarkable and/or comparable kind of inebriation. They called Lester Windell to come and get me.

In retrospect, this kind of obsessional search for spiritual authority equated in my mind with what was still called "love" in the fifties, that love-in decade or score of years. If this search conflicted with a marriage tradition, well, tough nouggies. Also in retrospect, I have had difficulty in not interpreting the venerable and regional institution of Friends as kind of on trial for suspect behavior, simply because unfamiliar. Yet I had found values for myself, "dysfunctional" though they might be to selected others. They were survival-power for me.

APPENDIX C

C. M. Bowra's treatment of poet Raphael Alberti I found helpful. (1957). He goes through a familiar sounding (!) crisis and writes a poem about it.

"Sobre Los Angeles" is concerned with a terrible crisis in which for no explicable reason he has lost his trust in himself and his hold on existence, that things which have hitherto meant much to him and guided and sustained him have suddenly left him, that he has been robbed not merely of his dreams and visions, but of everything which gives savour and significance to life, and he does not know what to think or what to do. Other men have gone through crises not entirely dissimilar. The mood which Coleridge sets out so poignantly in "Dejection", the torturing doubts which Tolstoi felt after the publication of "Anna Karenina", the collapse of confidence and zest of which Mill speaks in his "Autobiography", are a few of the dangers which threaten a man who gives all his powers to his work, only to find that he has lost something of inestimable value. Alberti's crisis has something in common with all of these. He too finds suddenly that his self-confidence has gone, that he has no taste for what used to delight him, that he sees no direction in which to move, that he is the prey of strange emotions and dark doubts. But in other ways his position is different. While Tolstoi and Mill encountered these obstacles in ripe middle age after busy lives, Alberti was still in his twenties. And partly because he is still a young man, he resists his crisis and fights against it...with violence and vigor.

The conclusion which the poem reaches is Faustian:

There is always something beyond what we now have, beyond even death, and this sense of an endless process, no matter how disastrous and painful, is what concerns the poet and the man.

Bowra thus summarizes Alberti's work:

At a time when a less courageous man might well have broken down under the shock of such a crisis, Alberti summoned all his powers and created a poetry with a most unusual concentration and intensity. In transcending his own crisis through the magic of his art, Alberti not only solves his own private problem, but enables others to face experiences like his own. The destructive powers which assail him in the very centre of his life become his instruments for a new creative outlook on some most important problems and are brought into a harmonious scheme which their very nature seemed at first to deny. Modern poetry may often seem to be concerned with disintegrating and depressing emotions, but at times it shows that they too can be made into a means for a greater sense of order and a new kind of harmony. In the last resort, the creative principle which works in such unexpected ways imposes its own discipline and dominion on the most intractable material.

APPENDIX D

BOOK RE-REVIEW, CLIFFORD W. BEERS

WHAT DID HE REALLY SAY IN HIS AUTOBIOGRAPHY?

Clifford W. Beers (1876-1943) was a Yale man with a disciplined mind so that when he was felled by an anxiety attack he was able to keep a critical core of sanity or reason, and his sense of humor was one of the pluses he had going for him after those days of coming into and going out of depression, or going in and staying in. If such can be said, his was more of a natural event than our technology sees it today. The anxiety-paranoia grows until he does not recognize his family members for who they are but rather as pretentious imposters -- his brother takes a power of attorney over him and Beers ceases to communicate with anybody for two years. Silent, he is obsessed with baseless guilt, fearful of becoming an epileptic, and he contemplates and even weakly tries suicide. His inner world becomes a phantasmagoria in which he hears false voices. He imagines himself on a ship. When food is brought, he thinks he is poisoned. He sees handwriting on his bedsheets, but he cannot read it. One of the happy episodes is when he is visited by the Kate Greenaway girls from his own childhood stories. With real zest, he again makes plans for killing himself. He says (p.113)

For the whole period of my intense excitement, there were certain persons who could control me, and certain others whose presence threw me into a state bordering on rage, and frequently into passions which led to distressing results.

Some episodes of Beers' recital are hilariously funny. He wants to collect corncobs from the farm granary and attach little thermometers to them, useful craft-pieces, but staff thinks the collection of the cobs themselves is totally mad and throws them away right in front of the irate inmate. For a while he has pencils and paper so he plunges with zest into the arts, but when these too are taken away, he cheerfully begins to write on the walls. For the entertainment of something to do, he tries a fake suicide, alarming staff beyond words and being a source of secret merriment to Beers. In his manic "elation", as he calls it, his confidence knows no bounds. With the unerring insolence of elation while he is drawing on the walls he thinks (p 119)

I question whether Raphael or Michaelangelo -- upon whom I then looked as mere predecessors -- ever put more feeling per square foot into their mural masterpieces.

Of course he gets beat up sometimes for his impertinences (What has Windell called attention to about violence and madness?).

Beers talks of experiencing "chemical" and "mechanical" restraints, (same as today only in nursing-homes instead of hospital wards), the former being a drug called hyoscine, the latter the canvas strait-jacket.

His next phase after his literary stage, Beers becomes an obsessed scientist trying to conquer gravity with an invention that suspends his bed: "For weeks I believed I had uncovered a mechanical principle which would enable man to defy gravity. (p. 156). Meanwhile Beers writes to the Governor to see what can be done about the abuse of patients (p. 196), and miracle of miracles the governor reads the letter:

"I take pleasure in informing you that I am in the Crazy Business and am holding my job down with ease and a fair degree of grace. Being in the Crazy Business, I unders'and certain phases of the business about which you know nothing. You

as Governor are at present 'head devil' in this 'hell.' though I know you are unconsciously acting as 'His Majesty's' 1st Lieutenant."

I then launched into my arraignment of the treatment of the insane. The method, I declared, was "wrong from start to finish. The abuses existing here exist in every other institution of the kind in the country. They are all alike -- though some of them are of course worse than others. Hell is hell the world over, and I might also add that hell is only a great big bunch of disagreeable details anyway. That's all an Insane Asylum is.

If you don't believe it, just go crazy and take up your abode here. In writing this letter I am laboring under no mental excitement. I am no longer subjected to the abuses about which I complain. I am well and happy. In fact I never was so happy as I am now. Whether I am in perfect mental health or not, I shall leave for you to decide. If I am insane today I hope I may never recover my Reason."

(p.200) "No doubt you will consider certain parts of this letter rather 'fresh.' I apologize for any such passages now, but, as I have an Insane License, I do not hesitate to say what I think. What's the use when one is caged like a criminal?

"P.S. This letter is a confidential one -- and is to be returned to the writer upon demand."

The letter was eventually forwarded to my conservator and is now in my possession.

As a result of my protest the Governor immediately interrogated the superintendent of the institution.

The epistolary section of the later editions of the Beers book mention the significance of World Wars I and II in nourishing mental health research (p. 308) and somebody refers to the new concepts as within categories which have nuclei but no boundaries. (I didn't know there was such a category, and if there still is, it would be a perfect receptacle for study of the life and significance of man himself!)

Beers comments on the influence of childhood environment that produces the no-no child, the temperamental "anti-" and the revolutionary, translated as the corresponding (1) solid citizen, (2) the prophet and the reformer, and (3) the poet and the artist. (p. 310) In the glory days of beginning it was believed that these new insights could be used to treat crime and delinquency (p. 311); school studies and the implementation of teachers have achieved more, far more, in this area than even Beers dreamed (p. 344).

Beers knew Booth Tarkington too.

The power to forget the past -- or recall it only at will -- has contributed much to my happiness (p. 204).

Of his adventure, in retrospect Beers says:

Should my condition ever demand it, I would again enter a hospital for the insane quite as willingly as the average person enters a hospital for the treatment of bodily ailments

I wonder if Beers is seeing clearly in this statement; he is talking about a cognitive process that includes trial/error judgment which sharpened once, would prevent a recurrence.

However, it is his experience that Beers turns into a plan that benefits all of society: he will write the book and establish the organization that will civilize psychiatric medicine and bring to it a "mental health" emphasis.

Being a Yale man, even being a crazy one has its advantages, because Beers established a friendship with Professor William James, whose later service to Beers as a consultant proved a great encouragement in working out details of Beers' organization for mental health. In those early years, backers were plentifully attracted with the promise that not only disturbed adults but also children would be helped. William Lawrence writes to Beers (p. 290):

The bare statement of the numbers of children and adults who are mentally hampered is startling. The immense and preventable wastage of life and efficiency in relation to the home, to industry, and to national defense is enough to arouse the nation.

He or another backer writes of the manifold problems of "adolescence where you can rescue boys and girls from their fears and depressions and despairs (p. 294)." For Beers is here taking a stand against the age-old resignation to fate by the general belief that "to be once insane was to be always insane." (p. 299)

APPENDIX E

REMARKS ON THE MUCH-REFERRED-TO 100 CASES

The definitive study of the effect of ECT on childhood schizophrenia was done in 1947 by Dr. Lauretta Bender at the children's ward in Bellevue Hospital in New York where she had access to 100 children. She had the confidence of the parents of the children, and they followed her suggestions in being a part of her team, as it were. The conclusions were that children get less confused during ECT than adults, and adults less than the elderly. There was not enough positive therapy indicated in the results, however, so that may be part of the reason the hypothesis of child-ECT has not continued in favor.

At the end of the article there was a short discussion by Lothar B. Kalinosky, who simply felt that childhood schizophrenia wasn't as hopeless a disease as claimed. He also noted the neurological implications (perhaps wondering why the ECT was not as devastating in children?)

Both this early literature as well as the recently reviewed material from fifty years earlier indicate that childhood schizophrenia was a real threat to parents, according to Clifford Beers, the father of the mental-health-in-education thrust, which has taken over the training of professionals to cope with child-adjustment, including the use of drugs to quiet the hyper. (Windell's remarks on Kalinosky's remarks; it must be remembered that today's children have problems undreamed of when the earlier publications appeared).

APPENDIX F

LETTERS

JOANNE GREENBERG

Golden, Colorado 80401

December 21, 1995

Dear Ms. Windell:

While I NEVER PROMISED YOU A ROSE GARDEN was changed to fit the requirements of artistic form, the material that was presented was primarily autobiographical, and the "Paradise Lost" section was personal experience.

Are you researching visions or hallucinations as a metaphor in art? That would be a very interesting study. I wish you good luck in it.

Sincerely,

signed - Joanne Greenberg

Madison State Hospital
Division of Mental Health
711 Green Road
Madison, IN 47250-2199

2/1/96

Violet Windell
4675 Davis Mill Rd NW
Ramsey, IN 47166-8211

Dear Violet,

I received your letter dated 1/18/96. I guess you could consider your letter "shocking" in view of the information you shared with me concerning your paper on Shock Therapy.

Good luck to you in bringing that long involvement to a final conclusion.

I am returning your letter to redirect as you find suitable.

Sincerely,

signed - Jim Courter
Rehab Therapy

UofL Health Science Center

November 30, 1995

Ms. Violet Bruner Windell
4675 Davis Mill Rd NW
Ramsey, IN 47166-8211

Dear Ms. Windell:

I received your letter of November 17, 1995 requesting an interview with me regarding electroshock therapy.

I did a literature search to see if any of our faculty have published in the area of electroshock therapy but did not find any publications by University of Louisville faculty. Perhaps you could contact other medical schools in Indiana and Kentucky regarding their faculty interest in this area.

Sincerely yours,

signed-
Nancy C. Martin, Ph.D
Associate Dean for Research

NCM:dkl

APPENDIX G - LIVING WITNESSES, BROTHER & SON

Audiotape Transcription (apparently also on videotape recording)

Violet Bruner Windell interview / discussion with Paul Bruner. Summer 1994

Ramsey, Indiana

PB Transcription, January 20, 1998

VB: Violet Windell

PB: Paul Bruner

Paul says we are getting pretty good at this aren't we? Violet says, it is about insanity, and Paul remarks about his breakfast . . .

PB: Now Violet, you said you wanted me to remember . . . in effect . . .

VB: Yes, from the perspective of the years that have passed, of what this twelve year old boy or whatever he was, saw as an observer . . . which is kind of remarkable, and I found it very helpful just now.

PB: And this observing as a twelve year old boy . . . of your being committed to Out Lady of Peace (mental hospital), which for lack of a better word, even then, was considered "Happy Valley" . . . just remember at the time that there was a lot of concern with Mother and Dad for you, and they didn't know what to do . . . Lester didn't know what to do, and nobody seemed to know what to do. Everybody felt sad about it, but that if they did this thing together then nobody would have to feel particularly guilty. Even though I don't know that it was said that way I know there was a real concern about it, and they just didn't know what to do, I think they suspected perhaps what was the problem, but for people from this area, well, anyone, any lay person, they don't feel like they have any kind of capacity to deal with what for them seemed like unusual behavior.

VB: And that's your typical social reaction today, as it was at that time . . .

PB: So, you were given over to the professionals . . . to be handled: I particularly thought at the time, and now as I am looking back on it . . . it was a lack, for a better word, of "courage" to deal with this unusual behavior . . . I mean how do you deal with something that you don't understand? And behavior that doesn't seem particularly rational in terms of this particular environment and what is expected as normal behavior from somebody. I am not saying that perhaps your behavior wasn't extreme, abnormal, and in some cases irrational. But, I just felt that the way that that was handled by the family, and I think the family usually does have to be involved, and it does mean that everyone does have to face up to the problem, that it is not just one person's problem, it is really a family problem and I realized that you, Violet, had been made a sacrifice at that time, and I think that I realized right then, that probably given my directions and my personality that I too would be visiting Lady of Peace if I stayed around this area, "this neck of the woods," as they say. So, that sacrifice was made once, and that price was paid once, I felt that if it wasn't going to be in vain, I had to get out and live my life and do what I had to do, but I had to find my courage, and I had to find some people and some places where that did not have to be re-enacted. It is something that I have always appreciated, and I feel that you did it for me, it was just that kind of thing, I think it has

affected your life since that moment on, and I think you have a lot of courage to come out of that and to do with your life. I am real proud of you, because it took some real courage . . . and you have done it, and you have overcome it. It is only with courage that you have been able to do that.

An artist friend of mine in New York once advised me, an artist that I respect very much, he had studied in Italy with an old master-artist: when he asked the old artist, "what does it take to be an artist?" the old man said, "couraggio, coraggio!" So, I think that is right, it does take real courage. For Violet, I am sure she entered in fear, and I am sure with great trepidation, but she came out of it, and that is when it took the courage. I just think it is really incredible that she has been able to come out and put that experience in some kind of context. It is also that she doesn't fear that but is able to look back on it and use it in a positive way. I think it is something that she wants to share. Unfortunately a lot of people are afraid to share it with her . . . I mean if people work with you, you can usually handle all of those kinds of problems, and those kinds of fears. That is my statement forever . . . on this!

VB: Thank you, it has such tremendous behavioral implications in what I am doing now in the way of research and study. And, I liked what you said just before we went on camera (tape) and you stated it a little differently, instead of using the word courage, you used the word strength. I think we were all looking for strength and there wasn't any strength.

PB: Yes, I said that the other night, I think we were looking for strength. Mother and Dad didn't have it as the parents, and Lester, the husband, didn't have it . . . and together, the three of them, they didn't have it. That, I think . . . among the three of them they could not find the strength, because that is what a family is . . . it should have that kind of strength and uh, I think they were just overruled by their fear. Their fear, coupled with your fear, I think it was, well, something nobody could just quite understand how to take responsibility for it. That is where the strength comes in, taking responsibility for it, taking responsibility for what has happened . . . also, sometimes reversing that, because things are going to happen . . . and it takes tremendous strength to reverse them, or set them on the right course, because nobody is on the "right" course . . . often we veer off of our track, mental and otherwise, so I think it takes real strength and conviction to sometimes right yourself, or certainly to work with another person. And, you really can't right the other person, all you can do is understand, and work with them . . . but I think it is important that you don't always give them over to a professional, or to totally professional care. It is real important.

VB: There is more emphasis today on it being a family situation than there was back then. The custom at that time and the community tradition was that if this happens to your family person, you send them off . . .

PB: you put them away . . . send them off to the crazy house, and of course there is a stigma with that. Once that happens, it goes forever . . . you don't get over it, it is not like an affliction or disease of the body where you get over it, and it heals. It is something like once that happens, other than something like cancer, which can come again, even if you think you've got it, I mean it is always there as a shadow, and I think there is a shadow in terms

of emotional difficulties that always hang with it, and go with it, so everybody just expects it as more irrational behavior. Sometimes it is, and sometimes it isn't, that is what is real important, a way of dealing with it when it is irrational, and yet sometimes it is rational, and it is real important that you have that kind of support, otherwise you are out there alone, and it really is fearful when you are just there by yourself . . . and you are looking for help and support, and there is just no one there.

VB: Yet the culture as a whole values the insights that came from irrational behavior in the past . . . back in bible times and so on, because prophets seemed to have a crazy streak . .

PB: Well, that is visionary . . .

VB: Visionary, yes!! but it isn't understood . . .

PB: Well, with science . . . we live in a highly scientific, I mean it is scientific materialism . . . so, the whole idea of being a visionary is itself very strange, and by that standard, Dad was strange, he was always into his prophecy . . . and nobody put him away.

VB: they just didn't pay any attention to him! (laughs)

PB: But that was the part of his convictions, his belief, and it was accepted as that. Because he did believe it. Well, also he basically worked interpretatively, and it wasn't so much by his overt behavior as it was his way of reading the bible, and all of his bibles, the King James and other versions . . . and he read all of that difficult work and certainly a lot of other religious kinds of propositions . . . coming from the Jehovah Witnesses to any kind of literature he could find, could put his hands on . . . and sifted through his own kind of mesh . . . to get, well, to further question what he believed and to develop his own prophecy and his kind of timelines and charts, where he felt, "were these the last days?" In some ways he wasn't anymore irrational, I mean in someways, that was his hobby. But, then again when he did his other work he didn't necessarily get involved with that when he became a minister. His behavior was quite consistent with interpreting the difficult writing of the bible, and it was quite legitimate. I think the difference is, that because you were an artist and looking at this from a very personal and bizarre kind of view, it wasn't given the legitimacy of an artistic viewpoint.

VB: Professionally, and in other ways I was just a bored and boring housewife.

PB: It was out of context, was its principal problem, and it was always the problem, I think. So, when you take something out of context it does seem like a bizarre behavior. But, having worked in New York for the advertising industry for a long time - many, many years . . . everybody goes to the psychiatrist. In a creative industry like that, you have to be . . . you are always going off into irrational kinds of thinking and thoughts . . . you have to, because you are stretching to come up with new ideas and news ways, not new ways of looking at things, but new angles of looking at things. Sometimes you are just revising old things and

trying to make them look new because you are trying to promote and you are trying to sell. You are trying to manipulate people with these ideas. You are not dealing with truth, but you are dealing with consumerism. Everybody understands that you have to have bizarre thoughts, because you have to constantly be entertaining people with new ideas - titillating them. So, advertising in that sense, I mean people understand that if you are doing it to try and sell something, but, they don't necessarily understand it if you are trying to make art. Quite recently that has been the case. The artist has always been ahead of the society, kind of like a litmus paper, to see what is coming up. It is always irrational, art has never been a rational activity - not that I know of. It has to engage the subconscious, the surreal, the dream. If some of that had been included with you in the work at Lady of Peace it probably would not have been so clinically handled, it would have been more humane . . . and it would have been much more profitable probably. That is the kind of thing we all need, and it is probably ongoing . . . that kind of humanistic understanding. It was just that, again, I thought that there wasn't the strength of support that you needed at that time . . . and I didn't really feel that in the parents . . . my wife has always been very supportive . . . but then again, I left the area when I chose a helpmate, in that sense, who did offer me that strength and I certainly try to offer her that strength right back, because you need that other . . . you need all of the support you can get to survive anywhere. - normal, abnormal, whatever . . . you just need support. But, you are able to give support if you are able to receive support. Two sides of the same coin. you really do have to have a strong support system. Again, I think it comes from a strength of family. If you have it in the family, you can take it and extend it beyond the family. It is real important. I am glad to kind of give testimony and witness to your ordeal and, again, what I think is your tremendous courage to pick up and go on with life and continue as an artist with your beliefs. I think certainly Violet Bruner qualifies, she has just done fantastic things. I am real proud of her for what she has done. Certainly, and this is not pride, I am just grateful that she made that sacrifice, or she was sacrificed, it wasn't of her own volition. I do recognize that that sacrifice was made and I didn't feel it was necessary to go through that kind of ordeal again, certainly not for me. I am eternally grateful for that . . . Okay?

February 12, 1998

[Editorial note added to the Bruner - Windell Dialogue, but only for this publication and not also for the earlier video or audio.]

VB: Paul, I appreciate your sympathetic coverage of the description: May I question one earlier statement that my parents suspected a cause or causes for my breakdown; with mine being a "mental illness," neither they nor the professionals would seriously look for causes, or even side - effects of treatment, for that matter. So the electro therapy wasn't the shock, violent as it was. The real shock came when I was discharged, and at home in a sudden swerve of focus, I found the previous campus mentoring replaced in the wordless but aboutface concern from Kinsey Windell, coming out of the woodwork like a dark horse and making thinkable ideas that had been unthinkable before, offering an option still socially unacceptable, just different from the earlier one. And he could safely indicate that concern, then deny it if I recognized it, for I was the certified crazy one although before and after that, I had frequently referred to him as the mad scientist.

Disassociation

A Bird Leaves the Nest

Every offspring needs a parent, and thus we have the phenomenon of imprinting. Just as the first object seen by a newly hatched duckling imprints as its parent, so it is with human babies. A rock can function as a perfectly acceptable parent for the duckling or the child, but only up to a certain point.

Until I began the socialization imposed by elementary school, I knew nothing of shame. But the child who is perceived by his peers to be anything other than normal becomes the target of every kind of persecution. I quickly learned that I was the child of abnormal parents, and that I would be subjected to persecution for their flaws as well as my own.

My father was morbidly obese, and was always seen in public in sloppy, dirty clothing. His labors did not result in the kinds of success which were measured by contemporary standards. For some of my peers, their father was a source of great pride and boasting - if nothing more than "my dad can whip your dad." More often than not, I found myself wishing that I had no father. In time, I learned to conduct myself as though this were true. If I was asked "who are your parents?" I would typically respond "I have no parents. I was raised in the wilderness by wolves," alluding to the story of Romulus and Remus. The aspect of my father which I valued was that nobody thought he was crazy.

E. K. WINDELL (U. S. ARMY, RET.)
1997

WINDELLS' WISDOM

Any idea in our family , to have any value,must have three characteristics:

1. It must be complex
2. expensive
3. and foolish.

Psychology inspires IUS student to write sixth book

By Amany Ali
Associate Editor

Violet Bruner, a student at IUS, is currently writing a book that stemmed from a psychology paper about "Forced Forgetting."

This will be the sixth book that Bruner has written, including one autobiography. The book isn't complete and doesn't have a title yet, but Bruner expects it to be between 72 and 100 pages.

Bruner considers herself to be an artist who just wants to get her message out.

"I do it for the inner-drive of knowing that I have to get the message out," she said.

Aside from writing books, Bruner has also written a monthly column, entitled "Filler," for the Corydon Democrat, and she has published her work in the Clarion newspaper.

"I'm proud to have my work published in a respectable paper," Bruner said.

Although Bruner enjoys writing books and doing artwork, she doesn't have the drive to get the books published because she thinks it's too much work and the rejection from publishing houses is too discouraging.


"If I try to publish something and it doesn't work out, I think, well, that's something I tried, and I move on" Bruner said.

Equipped with a BA in art history, a MA in English and humanities from the University of Louisville, and an MS in education from IUS, Bruner considers herself to be an artist—an artist with a message.

"I like being able to talk about it and letting people know about it," Bruner said.

Bruner thinks education is the key.

"Education is life-long learning that's important to some of us," Bruner said. "It's a buffer to continue learning."

 Violet B. Windell
4675 Davis Mill Rd. NW
Ramsey, IN 47166



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